

Guide to Using Draft 837 Document

Industry Name: Name in implementation guide (IG).

Data Element: It is the smallest named unit of information in the ASC X12 standard. Each data element is assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length.

Element Name: The name of the data element.

Type: The data element type:

Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Field Length – Minimum: The minimum number of characters in the data element.

Field Length – Maximum: The maximum number of characters in the data element.

Element Definition: Description of the data element.

Required or Situational: Whether this data element is required or situational.

In Implementation Guide: Whether the codes are listed in the implementation guides:

Y	Yes
NA	Not Applicable-No code list required (i.e., for a date or amount)
CL	Not in implementation guide, but in an external code list (CPT-4 book, zip code book, etc.)

Commentary: Additional information/observations.

Currently Captured by DMH: “Yes” if currently captured in DMH computer system (i.e., CTRAC, POS, MEIS, Services, etc.).

Service: Noted when data element is used exclusively for a specific service. Some of the data elements are used only for specific services (home health, ambulance services, coordination of benefits (COB), claims repricing, etc.)

Client, Provider, or Claim Data: Each data element was also analyzed as to whether it pertained to client demographics (CD), provider information (PI), or claims data. Claims data was broken into the following subcategories:

CI	Claims Information
CI-COB	Claims Information – Coordination of Benefits
CI-CR	Claims Information – Claims Repricing
CI-HH	Claims Information – Home Health
CI-SM	CI-SM – Claims Information – Spinal Manipulation
CP	Claims Processing

CI covers most claims, but some data elements were broken out so that you can easily identify and ignore these if you do not offer those services. Most of the data elements marked CP will be system-generated fields.

Implementation Guides: There are three 837 implementation guides (IGs): Institutional, Dental, and Professional. Some data elements are in one or more of the 837 IGs. An “X” indicates that this data element is in that IG, and the column to its right references the pages in the IG where that data element can be found.

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All data elements - in order by Industry Name				FIELD LENGTH																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																										
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All data elements - in order by Industry Name						FIELD LENGTH		Required or Situat'l In Impl'n Guide		Currently captured by DMH	Service	Client, Provider, or Claim Data	Implementation Guide		Implementation Guide		Implementation Guide	
Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Anesthesia Modifying Units	380	Quantity	R	1	15	Unit quantity for qualifying extenuating circumstances at time of service.	S	NA		No		CI					X	463
Anesthesia Unit Count	380	Quantity	R	1	15	Number of anesthesia units provided to patient	S	NA		No		CI			X	282		
Approved Amount	782	Monetary Amount	R	1	18	Amount approved.	S	NA		No	COB	CI-COB			X	221, 287	X	333, 485
Arterial Blood Gas Quantity	380	Quantity	R	1	15	The Arterial Blood Gas test results breathing room air (furnish results of recent hospital tests).	S	NA		No		CI					X	424
Assessment Date	1251	Date Time Period	AN	1	35	Date on which patient assessment or other required assessment was performed	S	NA		Yes		CI	X	459				
Assigned Number	554	Assigned Number	N0	1	6	Number assigned for differentiation within a transaction set.	R	NA		No		CP	X	444	X	265	X	399
Assumed or Relinquished Care Date	1251	Date Time Period	AN	1	35	Date post-operative care was assumed by another provider, or date provider ceased post-operative care.	S	NA		No		CI					X	213
Attachment Control Number	67	Identification Code	AN	2	80	Identification number of attachment related to the claim.	S	M	Needed if there are paper attachments to a claim.	No		CI	X	175, 454	X	172	X	216
Attachment Description	352	Description	AN	1	80	Free-form text describing attachments related to the claim.	S	NA	Needed if there are paper attachments to a claim.	No		CI	X	175				
Attachment Report Type Code	755	Report Type Code	ID	2	2	Code to specify the type of attachment that is related to the claim.	S	Y	Needed if there are paper attachments to a claim.	No		CI	X	174, 453	X	171	X	215, 410
Attachment Transmission Code	756	Report Transmission Code	ID	1	2	Code defining timing, transmission method or format by which an attachment report is to be sent or has been sent.	S	Y	Needed if there are paper attachments to a claim.	No		CI	X	174, 454	X	171	X	216, 411
Attending Physician First Name	1036	Name First	AN	1	25	First name of the physician responsible for care of the patient.	S	NA		Yes		PI	X	322, 463				
Attending Physician Last Name	1035	Name Last or Organization Name	AN	1	35	Last name of the physician responsible for care of the patient.	S	NA		Yes		PI	X	322, 463				
Attending Physician Middle Name	1037	Name Middle	AN	1	25	Middle name of the physician responsible for care of the patient	S	NA		Yes		PI	X	322, 463				
Attending Physician Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the physician responsible for the care of the patient	S	NA		Yes		PI	X	323, 463				
Attending Physician Primary Identifier	67	Identification Code	AN	2	80	Primary identification number of the physician responsible for care of the patient.	S	NA		Yes		PI	X	323, 463				
Attending Physician Secondary Identifier	127	Reference Identification	AN	1	30	Secondary identification number of the physician responsible for the care of the patient	S	NA		Yes		PI	X	327, 468				
Auto Accident State or Province Code	156	State or Province Code	ID	2	2	State or Province where auto accident occurred.	S	CL		No		CI	X	162	X	154	X	177
Begin Therapy Date	1251	Date Time Period	AN	1	35	Date therapy begins.	S	NA		No	M'care DMERC	CI					X	441
Benefits Assignment Certification Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.	R	Y		No	COB	CI-COB	X	160, 390	X	153, 229	X	175, 345
Billing Note Text	352	Description	AN	1	80	Free-form text providing additional information about the bill or claim being submitted.	S	NA		No		CI	X	209				
Billing Provider Additional Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the billing provider	S	NA		No		PI	X	84	X	84	X	92
Billing Provider Additional Name	93	Name	AN	1	60	Additional names or characters for the billing provider or billing entity for the transaction.	S	NA	This is only required if the name is over 35 characters.	No		PI			X	79	X	87

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837- Dental	Page #	837- Professional	Page #
Billing Provider Address Line	166	Address Information	AN	1	55	Address line of the billing provider or billing entity address.	R	NA		Yes			PI	X	79	X	80	X	88
Billing Provider City Name	19	City Name	AN	2	30	City of the billing provider or billing entity	R	NA		Yes			PI	X	80	X	81	X	89
Billing Provider Contact Name	93	Name	AN	1	60	Person at billing organization to contact regarding the billing transaction.	S	NA		No			PI	X	88			X	97
Billing Provider Credit Card Identifier	127	Reference Identification	AN	1	30	Identification number for credit card processing for the billing provider or billing entity	S	NA		No			PI	X	86	X	86	X	95
Billing Provider First Name	1036	Name First	AN	1	25	First name of the billing provider or billing entity	S	NA		Yes			PI			X	77	X	85
Billing Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.	R	NA		Yes			PI	X	78	X	78	X	86
Billing Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the provider billing or billing entity for services.	R	NA		Yes			PI	X	77	X	77	X	85
Billing Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the billing provider or billing entity	R	NA		Yes			PI			X	77	X	85
Billing Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix, including generation, for the name of the provider or billing entity submitting the claim.	R	NA		Yes			PI			X	77	X	86
Billing Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal zone code or ZIP code for the provider or billing entity billing for services.	R	CL		Yes			PI	X	81	X	82	X	90
Billing Provider State or Province Code	156	State or Province Code	ID	2	2	State or province for provider or billing entity billing for services.	R	CL		Yes			PI	X	81	X	82	X	90
Bundled or Unbundled Line Number	554	Assigned Number	N0	1	6	Identification of line item bundled or unbundled by payer in coordination of benefits.	S			No			CP	X	493	X	304	X	557
Certification Condition Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Code indicating whether or not the condition codes apply to the patient or another entity.	S			No			CI	X	219			X	258, 261, 264, 428, 433
Certification Condition Indicator	1136	Code Category	ID	2	2	Code indicating whether or not the condition codes apply to the patient or another entity.	S			No			CI	X	221, 224				
Certification Period Projected Visit Count	1470	Number	N0	1	9	Total visits projected during this certification period.	S	NA		No		Home Hlth	CI-HH					X	277
Certification Revision Date	1251	Date Time Period	AN	1	35	Date the certification was revised.	S	NA		No			CI					X	438
Certification Type Code	1322	Certification Type Code	ID	1	1	Code indicating the type of certification	S	Y		No			CI	X	213			X	421, 424
Claim Adjustment Group Code	1033	Claim Adjustment Group Code	ID	1	2	Code identifying the general category of payment adjustment.	S	Y		No			CI	X	367, 495	X	216, 307	X	326, 560
Claim Days Count	380	Quantity	R	1	15	The number of categorized days associated with the claim, such as lifetime reserve days, covered days.	S	NA		No			CI	X	307				
Claim Disproportionate Share Amount	782	Monetary Amount	R	1	18	Sum of operating capital disproportionate share amounts for this claim.	S	NA		No		M'care inpatient	CI	X	393				
Claim DRG Amount	782	Monetary Amount	R	1	18	Total of Prospective Payment System operating and capital amounts for this claim.	S	NA		No		M'care inpatient	CI	X	393				
Claim DRG Outlier Amount	782	Monetary Amount	R	1	18	Total Prospective Payment System Outlier and Capital Outlier amounts for this claim.	S	NA		No		DRG	CI	X	375				
Claim ESRD Payment Amount	782	Monetary Amount	R	1	18	End Stage Renal Disease (ESRD) payment amount for the claim.	S	NA		No		M'care outpatient	CI	X	399				

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum								837-Institutional	Page #	837-Dental	Page #	837-Professional	Page #
Claim Filing Indicator Code	1032	Claim Filing Indicator Code	ID	1	2	Code identifying type of claim or expected adjudication process.	S	Y		No	COB	CI-COB	X	104, 363	X	101, 211	X	112, 321
Claim Frequency Code	1325	Claim Frequency Type Code	ID	1	1	Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.	R	M		No		CI	X	159			X	173
Claim HCPCS Payable Amount	782	Monetary Amount	R	1	18	Sum of payable line item amounts for HCPCS codes billed on this claim.	S	NA		No	M'care outpatient	CI	X	398				
Claim Indirect Teaching Amount	782	Monetary Amount	R	1	18	Total of operating and capital indirect teaching amounts for this claim.	S	NA		No	M'care inpatient	CI	X	395				
Claim MSP Pass-through Amount	782	Monetary Amount	R	1	18	Interim cost pass-though amount used to determine Medicare Secondary Payer liability.	S	NA		No	M'care inpatient	CI	X	394				
Claim Note Text	352	Description	AN	1	80	Narrative text providing additional information related to the claim.	S	NA	This is for when you need to note additional information.	No		CI	X	207	X	186, 288	X	247
Claim or Encounter Identifier	640	Transaction Type Code	ID	2	2	Code indicating whether the transaction is a claim or reporting encounter information.	R	Y		No		CI	X	59	X	56	X	65
Claim Original Reference Number	127	Reference Identification	AN	1	30	Number assigned by a processor to identify a claim.	S	NA		No		CP	X	192	X	180	X	230
Claim PPS Capital Amount	782	Monetary Amount	R	1	18	Total Prospective Payment System (PPS) capital amount payable for this claim as output by PPS PRICER.	S	NA		No	M'care inpatient	CI	X	394				
Claim PPS Capital Outlier Amount	782	Monetary Amount	R	1	18	Total Prospective Payment System capital day or cost outlier payable for this claim, excluding operating outlier amount.	S	NA		No	M'care inpatient	CI	X	395				
Claim Submission Reason Code	1325	Claim Frequency Type Code	ID	1	1	Code identifying reason for claim submission	R	M		No		CI			X	151		
Claim Submission Reason Code	1383	Claim Submission Reason Code	ID	2	2	Code identifying reason for claim submission	S	Y		No		CI			X	155		
Claim Total Denied Charge Amount	782	Monetary Amount	R	1	18	Total amount of charges that were denied for this claim.	S	NA		No	COB	CI-COB	X	387				
Clearinghouse Trace Number	127	Reference Identification	AN	1	30	Unique tracking number for the transaction assigned by a clearinghouse.	S	NA		No		CP					X	239
Clinical Laboratory Improvement Amendment Number	127	Reference Identification	AN	1	30	The CLIA Certificate of Waiver or the CLIA Certificate of Registration Identification Number assigned to the laboratory testing site that rendered the services on this claim.	S	NA		No		CI					X	232, 476
Code Category	1136	Code Category	ID	2	2	Specifies the situation or category to which the code applies.	S	Y		No		CI	X	218			X	257, 260, 263, 427, 431, 433
Code List Qualifier Code	1270	Code List Qualifier Code	ID	1	3	Code identifying a specific industry code list.	R	Y		No		CI	X	228-230, 232-240, 242, 244-254, 256-265, 267-278, 280-288, 290-305	X	271	X	568
Communication Number	364	Communication Number	AN	1	80	Complete communications number including country or area code when applicable	R	NA	This is the biller's phone/fax/e-mail/edi number.	Yes		CI	X	65, 66, 88, 89	X	64, 65, 244, 245	X	72, 73, 97, 98, 364, 365, 539, 540
Communication Number Qualifier	365	Communication Number Qualifier	ID	2	2	Code identifying the type of communication number	R	Y		No		CI	X	65, 66, 88, 89	X	64, 65, 244, 245	X	72, 73, 97, 98, 364, 365, 539, 540

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Complication Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code to indicate whether the Patient's condition is Complicated or Uncomplicated.	S	Y		No	Spinal Manip	CI-SM					X	255, 419
Condition Code	1271	Industry Code	AN	1	30	Code(s) used to identify condition(s) relating to this bill or relating to the patient.	S	M		No		CI	X	291-298				
Condition Code	1321	Condition Indicator	ID	2	2	Code(s) used to identify condition(s) relating to this bill or relating to the patient.	S	Y		No		CI					X	258, 259, 261, 262, 428, 429
Condition Indicator	1321	Condition Indicator	ID	2	2	Code indicating a condition	S	Y		No		CI					X	431, 433, 434
Contact Function Code	366	Contact Function Code	ID	2	2	Code identifying the major duty or responsibility of the person or group named.	R	Y		No		CI	X	65, 88	X	64, 244	X	72, 97, 364, 539
Contract Amount	782	Monetary Amount	R	1	18	Fixed monetary amount pertaining to the contract	S	NA		Yes		CI	X	177			X	218, 467
Contract Code	127	Reference Identification	AN	1	30	Code identifying the specific contract, established by the payer.	S	M		No		CI	X	177			X	218, 467
Contract Percentage	332	Percent	R	1	6	Percent of charges payable under the contract	S	NA		No		CI	X	177			X	218, 467
Contract Type Code	1166	Contract Type Code	ID	2	2	Code identifying a contract type	S	Y		No		CI	X	176			X	217, 466
Contract Version Identifier	799	Version Identifier	AN	1	30	Identification of additional or supplemental contract provisions, or identification of a particular version or modification of contract.	S	M		No		CI	X	177			X	218, 467
Coordination of Benefits Code	1143	Coordination of Benefits Code	ID	1	1	Code identifying whether there is a coordination of benefits	R	Y		Yes	Dental	CI			X	100		
Coordination of Benefits Total Submitted Charge Amount	782	Monetary Amount	R	1	18	The total coordination of benefit charges submitted applicable to the claim.	S	NA		Yes	COB	CI-COB	X	373				
Co-Pay Status Code	1327	Copay Status Code	ID	1	1	A code indicating the status of the co-payment requirements for this service.	S	Y		No	COB	CI-COB					X	407
Cost Report Day Count	380	Quantity	R	1	15	The number of days that may be claimed as Medicare patient days on a cost report.	S	NA		Yes	M'care inpatient	CI	X	395				
Country Code	26	Country Code	ID	2	3	Code indicating the geographic location.	S	CL	This is required when the biller's address is outside the United States.	No		CI	X	81, 96, 114, 131, 138, 150, 163, 356, 407, 414	X	82, 93, 110, 142, 154, 237	X	90, 105, 123, 136, 145, 163, 178, 309, 356, 520, 535
Covered Amount	782	Monetary Amount	R	1	18	Amount determined to be covered for the claim for coordination of benefits.	S	NA		Yes	COB	CI-COB			X	224		
Covered Days or Visits Count	380	Quantity	R	1	15	Number of days or visits covered by the primary payer or days/visits that would have been covered had Medicare been primary.	S	NA	Medicare lifetime reserve day count.	No	M'care inpatient	CI	X	393				
Credit or Debit Card Authorization Number	127	Reference Identification	AN	1	30	Credit/Debit card authorization number used to authorize use of card for payment for billed charges.	S	NA		No		CI-COB	X	125	X	130	X	150
Credit or Debit Card Holder Additional Name	93	Name	AN	1	60	Additional name information for the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA	This is only required if the name is over 35 characters.	No		CI-COB			X	129	X	149
Credit or Debit Card Holder First Name	1036	Name First	AN	1	25	First name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB	CI-COB	X	122			X	147
Credit or Debit Card Holder Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB	CI-COB	X	122	X	127	X	147
Credit or Debit Card Holder Middle Name	1037	Name Middle	AN	1	25	Middle name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB	CI-COB	X	122	X	127	X	147

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Credit or Debit Card Holder Name Suffix	1039	Name Suffix	AN	1	10	Name suffix of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB	CI-COB	X	122	X	127	X	147	
Credit or Debit Card Maximum Amount	782	Monetary Amount	R	1	18	Dollar limit for a credit or debit card	S	NA		No	COB	CI-COB	X	184	X	174	X	219	
Credit or Debit Card Number	67	Identification Code	AN	2	80	Credit/Debit card number that may be used to pay for billed charges.	S	NA		No	COB	CI-COB	X	123	X	128	X	148	
Currency Code	100	Currency Code	ID	3	3	Code for country in whose currency the charges are specified.	S	CL	Only needed for foreign currency.	No		CI	X	74	X	74	X	82	
Date Claim Paid	1251	Date Time Period	AN	1	35	Code indicating the date the claim was paid.	S	NA		No		CP			X	246			
Date Time Period	1251	Date Time Period	AN	1	35	Expression of a date, a time, or a range of dates, times, or dates and times.	S	Y		No		CI	X	243					
Date Time Period Format Qualifier	1250	Date Time Period Format Qualifier	ID	2	3	Code indicating the date format, time format, or date and time format	S	Y	Required when the patient is the same as the subscriber.	No		CI	X	115, 151, 165, 167, 169, 211, 215, 243, 245-255, 257-266, 268-278, 388, 415, 457, 458, 502	X	111, 143, 157, 158, 160-162, 164, 227, 246, 273, 275, 277, 279, 312	X	115, 124, 155, 164, 180 182, 184, 186, 189, 190, 192, 194, 196, 197, 199-201, 203, 205, 206, 208, 210, 213, 342, 366, 436, 437, 439, 440, 443-445, 447, 450-452, 454, 456, 458, 460, 566	
Date Time Qualifier	374	Date/Time Qualifier	ID	3	3	Code specifying the type of date or time or both date and time.	S	Y		No		CI	X	165, 167, 169, 415, 456, 458, 502	X	157, 158, 160-162, 164, 246, 273, 275, 277, 279, 312	X	180, 182, 184, 186, 188, 190, 192, 194, 196, 197, 199-201, 203, 205, 206, 208, 210, 213, 366, 435, 437, 439, 440, 442, 444, 445, 447, 449, 451, 452, 454, 456, 458, 460, 566	
Delay Reason Code	1514	Delay Reason Code	ID	1	2	Code indicating the reason why a request was delayed.	S	Y		No		CI	X	164	X	155	X	179	
Delivery Pattern Time Code	679	Ship/Delivery Pattern Time Code	ID	1	1	Code which specifies the time delivery pattern of the services..	S	Y		No	Home Hlth	CI-HH	X	320			X	281, 494	
Demonstration Project Identifier	127	Reference Identification	AN	1	30	Identification number for a Medicare demonstration project.	S	Y/ NA		No	Demo Projects	CI	X	202			X	243	
Diagnosis Code	1271	Industry Code	AN	1	30	An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition.	R	M	ICD-9 required	Yes		CI					X	266-270	
Diagnosis Code Pointer	1328	Diagnosis Code Pointer	N0	1	2	A pointer to the claim diagnosis code in the order of importance to this service	R	Y		No		CI					X	405	
Diagnosis Date	373	Date	DT	8	8	Date the diagnosis was established or recorded.	S	NA		No	Home Hlth	CI-HH	X	212, 216, 217					
Diagnosis Related Group (DRG) Code	1271	Industry Code	AN	1	30	Diagnosis related group for this claim.	S	M		No		CI	X	230					
Diagnosis Type Code	1270	Code List Qualifier Code	ID	1	3	Code identifying the type of diagnosis.	S	Y		No		CI					X	266-270	
Disability From Date	1251	Date Time Period	AN	1	35	The beginning date the patient, in the provider's opinion, was or will be unable to perform the duties normally associated with his/her work.	S	NA		No		CI					X	202	
Disability To Date	1251	Date Time Period	AN	1	35	The ending date the patient, in the provider's opinion, will be able to perform the duties normally associated with his/her work.	S	NA		No		CI					X	204	
Discharge Hour	1251	Date Time Period	AN	1	35	Hour that the patient was discharged from inpatient care.	S	NA		No		CI	X	166					

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837- Institutional	Page #	837- Dental	Page #	837- Professional	Page #
Discharge or End Of Care Date	1251	Date Time Period	AN	1	35	Date that the patient was discharged from inpatient care or care/treatment ended.	S	NA		No		CI			X	159		
Discipline Type Code	921	Discipline Type Code	ID	2	2	Code indicating discipline(s) ordered by the physician.	S	Y		No	Home Hlth	CI-HH	X	314			X	276
Document Control Identifier	127	Reference Identification	AN	1	30	Internal control number assigned by a payer to facilitate retrieval or association of a claim.	S	NA		No		CP	X	189				
Durable Medical Equipment Duration	380	Quantity	R	1	15	Length of time durable medical equipment (DME) is needed.	S	NA		No	DME	CI					X	422
Duration of Visits Units	615	Time Period Qualifier	ID	1	2	The unit (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit every three days occurs over a duration of days.	S	NA		No	Home Hlth	CI-HH	X	318			X	280, 493
Duration of Visits, Number of Units	616	Number of Periods	NO	1	3	The number of units (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit every three days occurs over a duration of days.	S	NA		No	Home Hlth	CI-HH	X	318			X	280, 493
Emergency Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not emergency care was rendered in response to the sudden and unexpected onset of a medical condition, a severe injury, or an acute exacerbation of a chronic condition which was threatening to life, limb or sight.	S	NA		No		CI					X	406
End Stage Renal Disease Payment Amount	782	Monetary Amount	R	1	18	Amount of payment under End Stage Renal Disease benefit.	S	NA		No		CI					X	349
Entity Identifier Code	98	Entity Identifier Code	ID	2	3	Code identifying an organizational entity, a physical location, property or an individual	R	Y		No		CI	X	62, 68, 74, 77, 92, 109, 122, 127, 135, 145, 322, 329, 336, 343, 350, 401, 410, 421, 425, 429, 433, 437, 441, 463, 470, 477, 484	X	60, 67, 74, 77, 88, 104, 118, 136, 188, 196, 204, 232, 240, 254, 258, 262, 290, 298	X	68, 75, 82, 85, 100, 118, 131, 140, 147, 157, 283, 291, 299, 304, 313, 351, 360, 375, 379, 383, 387, 391, 395, 502, 510, 515, 524, 530, 542, 550
Entity Type Qualifier	1065	Entity Type Qualifier	ID	1	1	Code qualifying the type of entity	R	Y		No		CI	X	62, 68, 77, 92, 109, 122, 127, 135, 146, 322, 329, 336, 343, 350, 401, 411, 421, 425, 429, 433, 437, 441, 463, 470, 477, 484	X	60, 67, 77, 88, 104, 118, 127, 137, 188, 196, 204, 232, 241, 254, 258, 262, 290, 298	X	68, 75, 85, 100, 118, 131, 140, 147, 158, 283, 291, 299, 304, 313, 351, 360, 375, 379, 383, 387, 391, 395, 502, 510, 515, 524, 530, 542, 550
Entity Type Qualifier	1036	Entity Type Qualifier	ID	1	1	Code qualifying the type of entity	S	NA		No		CI			X	127		
EPSDT Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not Early and Periodic Screening for Diagnosis and Treatment of children services are involved with this detail line.	S	NA		Yes		CI					X	406
Estimated Birth Date	1251	Date Time Period	AN	1	35	Date delivery is expected.	S	NA	For a pregnancy.	No		CI					X	199
Estimated Claim Due Amount	782	Monetary Amount	R	1	18	The amount estimated by the provider to be due from the payer.	S	NA		No		CI	X	179				
Exception Code	1527	Exception Code	ID	1	2	Exception code generated by the Third Party Organization.	S	Y		No		CI	X	313			X	275, 500
Explanation of Benefits Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Indicator of whether a paper explanation of benefits (EOB) is requested.	R	Y		No		CI	X	163				

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Facility Code Qualifier	1332	Facility Code Qualifier	ID	1	2	Code identifying the type of facility referenced.	R	Y			No		CI	X	159				
Facility Tax Amount	782	Monetary Amount	R	1	18	The amount of facility tax or surcharge applicable to the reported service	S	NA			No		CI	X	461				
Facility Type Code	1331	Facility Code Value	AN	1	2	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.	R	Y			No		CI	X	159	X	151, 268	X	173
Family Planning Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not Family Planning Services are involved with this detail line.	S	Y			No		CI					X	406
Fixed Format Information	449	Fixed Format Information	AN	1	80	Data in fixed format agreed upon by sender and receiver	S	NA	Not used at this time.		No		CI	X	204			X	245, 487
Form Identifier	1271	Industry Code	AN	1	30	Letter or number identifying a specific question.	S	M			No		CI					X	568
Frequency Count	1167	Sample Selection Modulus	R	1	6	The count of the frequency units of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit occurs at three day intervals.	S	NA			No	Home Hlth	CI-HH	X	318			X	280, 493
Frequency Period	355	Unit or Basis for Measurement Code	ID	2	2	The units specifying the frequency of home health visits (e.g., days, months, etc.) Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit occurs at a frequency of days.	S	NA			No	Home Hlth	CI-HH	X	317			X	279, 492
Functional Limitation Code	1073	Condition Indicator	ID	2	2	Code describing the patient's functional limitations as assessed by the physician.	S	Y			No	Home Hlth	CI-HH	X	222, 225				
Functional Limitation Code	1321	Condition Indicator	ID	2	2	Code describing the patient's functional limitations as assessed by the physician.	S	Y			No	Home Hlth	CI-HH	X	219, 220				
HCPCS Payable Amount	782	Monetary Amount	R	1	18	Amount due under Medicare HCPCS system.	S	NA			No	M'care Outpatie nt	CP					X	348
Hierarchical Child Code	736	Hierarchical Child Code	ID	1	1	Code indicating if there are hierarchical child data segments subordinate to the level being described.	R	Y			No		CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
Hierarchical ID Number	628	Hierarchical ID Number	AN	1	12	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.	R	NA			No		CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
Hierarchical Level Code	735	Hierarchical Level Code	ID	1	2	Code defining the characteristic of a level in a hierarchical structure.	R	Y			No		CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
Hierarchical Parent ID Number	734	Hierarchical Parent ID Number	AN	1	12	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.	R	NA			No		CP	X	100, 140	X	97, 133	X	109, 153
Hierarchical Structure Code	1005	Hierarchical Structure Code	ID	4	4	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	R	Y			No		CP	X	57	X	54	X	63
Home Health Certification Period	1251	Date Time Period	AN	1	35	Certification period for home health care covered by this plan of treatment.	S	NA			No	Home Hlth	CI-HH	X	212				
Homebound Indicator	1321	Condition Indicator	ID	2	2	A code indicating whether a patient is homebound.	S	Y			No		CI					X	264
Hospice Employed Provider Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not the treatment in the Hospice was rendered by a Hospice employed provider.	S	NA			No	Hospice	CI					X	431

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837- Dental	Page #	837- Professional	Page #
Identification Code Qualifier	66	Identification Code Qualifier	ID	1	2	Code designating the system/method of code structure used for Identification Code (67)	R	Y		No			CI	X	62, 77, 92, 110, 123, 127, 147, 175, 323, 330, 337, 344, 350, 402, 411, 421, 454, 463, 470, 478,	X	60, 67, 78, 89, 105, 118, 128, 137, 172, 189, 197, 204, 233, 241, 254, 291, 298	X	68, 75, 86, 101, 119, 131, 147, 159, 216, 284, 292, 299, 305, 314, 352, 360, 375, 503, 510, 515, 525, 531, 543, 550
Immunization Batch Number	127	Reference Identification	AN	1	30	The manufacturer's lot number for vaccine used in immunization.	S	NA		No		Immunizations	CI					X	478
Individual Relationship Code	1069	Individual Relationship Code	ID	2	2	Code indicating the relationship between two individuals or entities			Differs from the information in CTRAC	No			CI	X	103, 142, 361	X	100, 134, 210	X	111, 154, 319
Industry Code	1271	Industry Code	AN	1	30	Code indicating a code from a specific industry code list.				No			CI	X	228, 229				
Information Receiver Identification Number	66	Identification Code Qualifier	ID	1	2	The identification number of the individual or organization who expects to receive information in response to a query.	R	Y		No			CP	X	68				
Initial Treatment Date	1251	Date Time Period	AN	1	35	Date that the patient initially sought treatment for this condition.	S	NA		No			CI					X	183, 459
Insurance Type Code	1336	Insurance Type Code	ID	1	3	Code identifying the type of insurance.	S	Y		No		COB	CI-COB					X	111, 321
Insured Group Name	93	Name	AN	1	60	Name of the group or plan through which the insurance is provided to the insured.	S	NA		Yes		COB	CI-COB	X	103	X	100	X	111
Insured Group or Policy Number	127	Identification Code	AN	2	80	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	S	NA		No		COB	CI-COB	X	103, 363	X	100, 210	X	111, 320
Insured Individual Death Date	1251	Date Time Period	AN	1	35	Date of death for subscriber or dependent.	S	NA		No		COB	CI-COB					X	115
Investigational Device Exemption Identifier	127	Reference Identification	AN	1	30	Number or reference identifying exemption assigned to an investigational device referenced in the claim.	S	NA		No			CI	X	193			X	236
Laboratory or Facility Address Line	166	Address Information	AN	1	55	Address line of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	NA		Yes			PI	X	354			X	307, 518
Laboratory or Facility City Name	19	City Name	AN	2	30	City of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	NA		Yes			PI	X	355			X	308, 519
Laboratory or Facility Name	1035	Name Last or Organization Name	AN	1	35	Name of laboratory or other facility performing Laboratory testing on the claim where the health care service was performed/rendered.	R	NA		Yes			PI	X	350	X	204	X	304, 515
Laboratory or Facility Name Additional Text	93	Name	AN	1	60	Additional name information identifying the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	S	NA	This is only required if the name is over 35 characters.	No			PI			X	206	X	306, 517
Laboratory or Facility Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP or zonal code of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	CL		Yes			PI	X	356			X	309, 520
Laboratory or Facility Primary Identifier	67	Identification Code	AN	2	80	Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.	R	NA		No			PI	X	350	X	204	X	305, 516
Laboratory or Facility Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	S	NA		No			PI	X	358	X	208	X	311
Laboratory or Facility State or Province Code	156	State or Province Code	ID	2	2	State or province of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	CL		Yes			PI	X	355			X	309, 520

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837 - Institutional	Page #	837 - Dental	Page #	837 - Professional	Page #
Last Admission Period	1251	Date Time Period	AN	1	35	Admission date of the most recent inpatient stay.	S	NA		No	Home Hlth	CI-HH	X	215				
Last Certification Date	1251	Date Time Period	AN	1	35	The date of the last certification.	S	NA		No	M'care DMERC	CI					X	443
Last Menstrual Period Date	1251	Date Time Period	AN	1	35	The date of the last menstrual period (LMP).	S	NA		No		CI					X	196
Last Seen Date	1251	Date Time Period	AN	1	35	Date the patient was last seen by the referring or ordering physician for a claim billed by a provider whose services require physician certification.	S	NA		No		CI					X	187, 446
Last Visit Date	373	Date	DT	8	8	Date the patient was last seen by the physician.	S	NA		No	Home Hlth	CI-HH	X	215				
Last Worked Date	1251	Date Time Period	AN	1	35	Date patient last worked at the patient's current occupation	S	NA		No		CI					X	205
Last X-Ray Date	1251	Date Time Period	AN	1	35	Date patient received last X-Ray.	S	NA		No		CI					X	198, 455
Lifetime Psychiatric Days Count	380	Quantity	R	1	15	Number of lifetime psychiatric days used for this claim.	S	NA		No	M'care inpatient	CI-COB	X	393				
Lifetime Reserve Days Count	380	Quantity	R	1	15	Number of lifetime reserve days used for this claim.	S	NA		No	M'care inpatient	CI-COB	X	393				
Line Item Charge Amount	782	Monetary Amount	R	1	18	Charges related to this service.	R	NA		No		CP	X	448	X	268	X	402
Line Item Control Number	127	Reference Identification	AN	1	30	Identifier assigned by the submitter/provider to this line item.	S	NA		No		CP			X	286	X	473
Line Item Denied Charge or Non-Covered Charge Amount	782	Monetary Amount	R	1	18	Line item charges denied or not covered.	S	NA		No		CP	X	449				
Line Note Text	352	Description	AN	1	80	Narrative text providing additional information related to the service line.	S	NA		No		CI					X	488
Location Qualifier	98	Entity Identifier Code	ID	2	3	Code identifying type of location.	S	Y		No	Dental	CI			X	127		
Loop Identifier Code	1065	Information Receiver Last or Organization Name	AN	1	1	The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE.	S	Y		No	Dental	CI			X	127		
Mammography Certification Number	127	Reference Identification	AN	1	30	HCFA assigned Certification Number of the certified mammography screening center	S	NA		No	Mammo gram	CI					X	226, 474
Measurement Qualifier	738	Measurement Qualifier	ID	1	3	Code identifying a specific product or process characteristic to which a measurement applies	S	Y		No		CI					X	465
Measurement Reference Identification Code	737	Measurement Reference ID Code	ID	2	2	Code identifying the broad category to which a measurement applies	S	Y		No		CI					X	465
Medical Record Number	127	Reference Identification	AN	1	30	A unique number assigned to patient by the provider to assist in retrieval of medical records.	S	NA	Used at discretion of submitter.	No		CI	X	201			X	241
Medicare Assignment Code	1359	Provider Accept Assignment Code	ID	1	1	An indication, used by Medicare or other government programs, that the provider accepted assignment.	R /S	Y	Always Required for professional billings. Situational for dental and institutional billings.	No		CI	X	160	X	152	X	174
Medicare Coverage Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code indicating the Medicare coverage exists.	S	Y		No	Home Hlth	CI-HH	X	213				
Medicare Paid at 100% Amount	782	Monetary Amount	R	1	18	Amount of charges reported to be paid by Medicare at 100% of allowed amount.	S	NA		No	COB	CI-COB	X	378				
Medicare Paid at 80% Amount	782	Monetary Amount	R	1	18	Amount of charges reported to be paid by Medicare at 80% of allowed amount.	S	NA		No	COB	CI-COB	X	380				
Medicare Section 4081 Indicator	127	Reference Identification	AN	1	30	Code indicating Medicare Section 4081 applies.	S	Y	This is only completed by Medicare.	No	COB	CI-COB					X	225

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum								837-Institutional	Page #	837-Dental	Page #	837-Professional	Page #
Mental Status Code	1321	Condition Indicator	ID	2	2	Codes describing the patient's mental condition.	S	Y		No	Home Hlth	CI-HH	X	225, 226				
Monthly Treatment Count	380	Quantity	R	1	15	Number of treatments rendered in the month of service.	S	NA		No	Spinal Manip	CI-SM					X	255, 419
Non-Covered Charge Amount	782	Monetary Amount	R	1	18	Charges pertaining to the related revenue center code that the primary payer will not cover.	S	NA		No	COB	CI-COB	X	386				
Nonpayable Professional Component Amount	782	Monetary Amount	R	1	18	Professional fees billed but not payable by payer.	S	NA		No	COB	CI-COB	X	395, 399				
Non-Payable Professional Component Billed Amount	782	Monetary Amount	R	1	18	Amount of non-payable charges included in the bill related to professional services.	S	NA		No	COB	CI-COB					X	349
Note Reference Code	363	Note Reference Code	ID	3	3	Code identifying the functional area or purpose for which the note applies.	S	Y		No		CI	X	206, 208	X	186, 288	X	247, 488
Number of Visits	380	Quantity	R	1	15	The number of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating the number of visits, i.e., one.	S	NA		No	Home Hlth	CI-HH	X	317			X	279, 492
Occurrence Code	1271	Industry Code	AN	1	30	Occurrence code as determined according to uniform bill instructions.	S	M		No		CI	X	268-278				
Occurrence or Occurrence Span Code Associated Date	1251	Date Time Period	AN	1	35	Date associated with indicated code value.	S	NA		No		CI	X	257-266				
Occurrence Span Code	1271	Industry Code	AN	1	30	A code that identifies an event that relates to payment of the claim. This event occurs over a span of days.	S	M		No		CI	X	257-266, 268-279				
Old Capital Amount	782	Monetary Amount	R	1	18	The amount for old capital for this claim.	S	NA		No	COB	CI-COB	X	394				
Onset Date	1251	Date Time Period	AN	1	35	Date of onset of indicated patient condition.	S	NA		No		CI					X	453
Onset of Current Illness or Injury Date	1251	Date Time Period	AN	1	35	Date of onset of indicated patient condition.	S	NA		No		CI					X	189
Operating Physician First Name	1036	Name First	AN	1	25	First name of the physician performing the principle procedure.	S	NA		No		PI	X	329, 470				
Operating Physician Last Name	1035	Name Last or Organization Name	AN	1	35	Last name of the physician performing the principle procedure.	S	NA		No		PI	X	329, 470				
Operating Physician Middle Name	1037	Name Middle	AN	1	25	Middle name of the physician performing the principal procedure	S	NA		No		PI	X	329, 470				
Operating Physician Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the physician performing the principal procedure	S	NA		No		PI	X	329, 470				
Operating Physician Primary Identifier	67	Identification Code	AN	2	80	Primary identifier of the physician performing the principle procedure.	S	NA		No		PI	X	330, 471				
Operating Physician Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the physician performing the principal procedure	S	NA		No		PI	X	334, 475				
Oral Cavity Designation Code	1361	Oral Cavity Designation Code	ID	1	3	Code identifying an oral cavity involved in the service.	R	Y		Yes	Dental	CI			X	268, 269		
Order Date	1251	Date Time Period	AN	1	35	Date the service(s) was ordered.	S	NA		No		CI					X	181, 444
Ordering Provider Address Line	166	Address Information	AN	1	55	Address line of the provider ordering services for the patient.	S	NA		No		PI					X	533
Ordering Provider City Name	19	City Name	AN	2	30	City of provider ordering services for the patient	S	NA		No		PI					X	534

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Ordering Provider Contact Name	93	Name	AN	1	60	Contact person to whom inquiries should be directed at the provider ordering services for the patient.	S	NA		No			PI					X	539
Ordering Provider First Name	1036	Name First	AN	1	25	The first name of the provider who ordered or prescribed this service.	S	NA		No			PI					X	530
Ordering Provider Identifier	67	Identification Code	AN	2	80	The identifier assigned by the Payer to the provider who ordered or prescribed this service.	S	NA		No			PI					X	531
Ordering Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the provider who ordered or prescribed this service.	S	NA		No			PI					X	530
Ordering Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider ordering services for the patient.	S	NA		No			PI					X	530
Ordering Provider Name Additional Text	93	Name	AN	1	60	Additional name infromation for the provider ordering services for the patient.	S	NA	This is only required if the name is over 35 characters.	No			PI					X	532
Ordering Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider ordering services for the patient.	S	NA		No			PI					X	530
Ordering Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the provider ordering services for the patient.	S	CL		No			PI					X	535
Ordering Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider ordering services for the patient.	S	NA		No			PI					X	537
Ordering Provider State Code	156	State or Province Code	ID	2	2	The State Postal Code of the provider who ordered / prescribed this service.	S	CL		No			PI					X	535
Originator Application Transaction Identifier	127	Reference Identification	AN	1	30	An identification number that identifies a transaction within the originator's applications system.	R	NA		No			CP	X	58	X	55	X	64
Orthodontic Banding Date	1251	Date Time Period	AN	1	35	Date that Orthodontic bands were applied.	S	NA		No	Dental		CI			X	163, 278		
Orthodontic Treatment Months Count	380	Quantity	R	1	15	Estimated Number of Treatment Months for Orthodontic Treatment	S	NA		No	Dental		CI			X	166		
Orthodontic Treatment Months Remaining Count	380	Quantity	R	1	15	Number of Treatment Months Remaining for Orthodontic Treatment	S	NA		No	Dental		CI			X	167		
Other Diagnosis	1271	Industry Code	AN	1	30	Other diagnosis for this claim.	S	NA		Yes			CI	X	233-240				
Other Insured Additional Identifier	127	Reference Identification	AN	1	30	Number providing additional identification of the other insured.	S	NA		No	COB		CI-COB	X	409	X	239	X	358
Other Insured Additional Name	93	Name	AN	1	60	Additional name information for the other insured.	S	NA	This is only required if the name is over 35 characters.	No	COB		CI-COB			X	234	X	353
Other Insured Address Line	166	Address Information	AN	1	55	Address line of the additional insured individual's mailing address.	S	NA		No	COB		CI-COB	X	404, 405	X	235	X	354
Other Insured Birth Date	1251	Date Time Period	AN	1	35	The birth date of the additional insured individual.	S	NA		No	COB		CI-COB	X	389	X	228	X	343
Other Insured City Name	19	City Name	AN	2	30	The city name of the additional insured individual.	S	NA		No	COB		CI-COB	X	406	X	236	X	355
Other Insured First Name	1036	Name First	AN	1	25	The first name of the additional insured individual.	S	NA		No	COB		CI-COB	X	401	X	232	X	351
Other Insured Gender Code	1068	Gender Code	ID	1	1	A code to specify the sex of the additional insured individual.	S	Y		No	COB		CI-COB	X	389	X	228	X	343
Other Insured Group Name	93	Name	AN	1	60	Name of the group or plan through which the insurance is provided to the other insured.	S	NA		No	COB		CI-COB	X	363			X	320
Other Insured Identifier	67	Identification Code	AN	2	80	An identification number, assigned by the third party payer, to identify the additional insured individual.	S	NA		No	COB		CI-COB	X	403	X	233	X	352

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Other Insured Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the additional insured individual.	S	NA		No	COB	CI-COB	X	401	X	232	X	351
Other Insured Middle Name	1037	Name Middle	AN	1	25	The middle name of the additional insured individual.	S	NA		No	COB	CI-COB	X	402	X	232	X	351
Other Insured Name Suffix	1039	Name Suffix	AN	1	10	The suffix to the name of the additional insured individual.	S	NA		No	COB	CI-COB	X	402	X	232	X	352
Other Insured Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The Postal ZIP code of the additional insured individual's mailing address.	S	CL		No	COB	CI-COB	X	407	X	237	X	356
Other Insured State Code	156	State or Province Code	ID	2	2	The state code of the additional insured individual's mailing address.	S	CL		No	COB	CI-COB	X	407	X	237	X	356
Other Payer Additional Name Text	93	Name	AN	1	60	Additional name information for the other payer organization.	S	NA	This is only required if the name is over 35 characters.	No	COB	CI-COB			X	242	X	362
Other Payer Address Line	166	Address Information	AN	1	55	Address line of the other payer's mailing address.	S	NA		No	COB	CI-COB	X	412				
Other Payer Attending Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's attending provider identification.	S	NA		No	COB	CI-COB	X	427				
Other Payer City Name	19	City Name	AN	2	30	The city name of the other payer's mailing address.	S	NA		No	COB	CI-COB	X	413				
Other Payer Claim Adjustment Indicator	127	Reference Identification	AN	1	30	Indicates the other payer has made a previous claim adjustment to this claim.	S	Y		No	COB	CI-COB			X	252	X	373
Other Payer Contact Name	93	Name	AN	1	60	Name of other payer contact.	S	NA		No	COB	CI-COB			X	244	X	364
Other Payer Covered Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be covered for the claim for coordination of benefits.	S	NA		No	COB	CI-COB					X	336
Other Payer Discount Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be subject to discount provisions.	S	NA		No	COB	CI-COB			X	225	X	337
Other Payer Identification Number	67	Identification Code	AN	2	80	The non-destination (COB) payer's identification number.	S	NA		No	COB	CI-COB					X	551
Other Payer Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The name of the other payer organization.	S	NA		No	COB	CI-COB	X	411	X	241, 298	X	360
Other Payer Operating Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's operating provider identification.	S	NA		No	COB	CI-COB	X	431				
Other Payer Other Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's other payer other provider identification.	S	NA		No	COB	CI-COB	X	435				
Other Payer Patient Last Name	1035	Name Last or Organization Name	AN	1	35	The non-destination (COB) payer's patient's last name.	S	NA		No	COB	CI-COB			X	254		
Other Payer Patient Paid Amount	782	Monetary Amount	R	1	18	Amount reported by other payer as paid by the patient	S	NA		No	COB	CI-COB	X	371	X	226	X	339
Other Payer Patient Primary Identifier	67	Identification Code	AN	2	80	The non-destination (COB) payer's patient primary identification number.	S	NA		No	COB	CI-COB	X	421	X	254	X	375
Other Payer Patient Primary Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's patient primary identification number.	S	NA		No	COB	CI-COB			X	256		
Other Payer Patient Responsibility Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be the amount owed by the patient.	S	NA		No	COB	CI-COB					X	335
Other Payer Patient Secondary Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's patient secondary identification number(s).	S	NA		No	COB	CI-COB	X	423			X	377
Other Payer Per Day Limit Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be the maximum payable per day under the contract.	S	NA		No	COB	CI-COB					X	338
Other Payer Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP code of the other payer's mailing address.	S	CL		No	COB	CI-COB	X	414				

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Other Payer Pre-Tax Claim Total Amount	782	Monetary Amount	R	1	18	Total claim amount before applying taxes as reported by other payer.	S	NA		No	COB	CI-COB						X	341
Other Payer Primary Identifier	67	Identification Code	AN	2	80	An identification number for the other payer.	S	NA		No	COB	CI-COB	X	411		X	241, 302	X	361, 555
Other Payer Prior Authorization or Referral Number	127	Reference Identification	AN	1	30	The non-destination (COB) payer's claim line level prior authorization or referral number.	S	NA		No	COB	CI-COB	X	419		X	249, 300	X	371, 552
Other Payer Purchased Service Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's purchased service provider identifier.	S	NA		No	COB	CI-COB						X	389
Other Payer Referral Number	67	Identification Code	AN	2	80	The non-destination (COB) payer's claim line level referral number.	S	NA		No	COB	CI-COB				X	299		
Other Payer Referring Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's referring provider identifier.	S	NA		No	COB	CI-COB	X	439		X	260	X	381
Other Payer Rendering Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's rendering provider identifier.	S	NA		No	COB	CI-COB				X	264		
Other Payer Rendering Provider Secondary Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's rendering provider identifier.	S	NA		No	COB	CI-COB						X	385
Other Payer Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the other payer organization	S	NA		No	COB	CI-COB	X	417		X	248	X	369
Other Payer Service Facility Location Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's service facility location identifier.	S	NA		No	COB	CI-COB						X	393
Other Payer Service Facility Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's service facility provider identifier.	S	NA		No	COB	CI-COB	X	443					
Other Payer State Code	156	State or Province Code	ID	2	2	The state or province code of the other payer's mailing address.	S	CL		No	COB	CI-COB	X	414					
Other Payer Supervising Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's supervising provider identifier.	S	NA		No	COB	CI-COB						X	397
Other Payer Tax Amount	782	Monetary Amount	R	1	18	Amount of taxes related to the claim as determined By other payer.	S	NA		No	COB	CI-COB						X	340
Other Physician First Name	1036	Name First	AN	1	25	The First Name of the other licensed physician.	S	NA		No			PI	X	336, 477				
Other Physician Identifier	67	Identification Code	AN	2	80	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.	S	NA		No			PI	X	337, 485				
Other Physician Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of the other licensed physician.	S	NA		No			PI	X	336, 477				
Other Provider Identifier	67	Identification Code	AN	2	80	The number of the other licensed provider.	S	NA		No			PI	X	478				
Other Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the other licensed provider.	S	NA		No			PI	X	337, 477				
Other Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the other licensed provider.	S	NA		No			PI	X	337, 478				
Other Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional name and/or number of the provider other than the attending provider as defined by the payer organization.	S	NA		No			PI	X	341, 482				
Oxygen Flow Rate	127	Reference Identification	AN	1	30	The oxygen flow rate in liters per minute.	S	Y		No			CI					X	481
Oxygen Saturation Quantity	380	Quantity	R	1	15	The oxygen saturation (oximetry) test results.	S	Y		No	Home Hlth	CI-HH						X	425
Oxygen Saturation Test Date	1251	Date Time Period	AN	1	35	Date patient received oxygen saturation test.	S	NA		No			CI					X	450
Oxygen Test Condition Code	1349	Oxygen Test Condition Code	ID	1	1	Code indicating the conditions under which a patient was tested.	S	Y		No	Home Hlth	CI-HH						X	425

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Oxygen Test Findings Code	1350	Oxygen Test Findings Code	ID	1	1	Code indicating the findings of oxygen tests performed on a patient.	S	Y		No	Home Hlth	CI-HH						X	425, 426
Paid From Part A Medicare Trust Fund Amount	782	Monetary Amount	R	1	18	Dollar amount paid for claim from the Part A Medicare Trust fund.	S	NA		No	COB	CI-COB	X	383					
Paid From Part B Medicare Trust Fund Amount	782	Monetary Amount	R	1	18	Dollar amount paid for claim from the Part B Medicare Trust fund.	S	NA		No	COB	CI-COB	X	385					
Paid Service Unit Count	380	Quantity	R	1	15	Units of service paid by the payer for coordination of benefits.	S	NA		No		CP				X	303	X	557
Participation Agreement	1360	Provider Agreement Code	ID	1	1	Code indicating a participating claim submitted by a non-participating provider.	S	Y		No		CI						X	178
Patient Account Number	1028	Claim Submitter's Identifier	AN	1	38	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim.	R	NA		No		CI	X	158	X	150	X		171
Patient Additional Name	93	Name	AN	1	60	Additional name information for the patient.	S	NA	This is only required if the name is over 35 characters.	No		CD				X	139	X	160
Patient Address Line	166	Address Information	AN	1	55	Address line of the street mailing address of the patient.	R	NA		Yes		CD	X	148	X	140	X		161
Patient Amount Paid	782	Monetary Amount	R	1	18	The amount the provider has received from the patient (or insured) toward payment of this claim.	S	NA		Yes		CD	X	183	X	173	X		220
Patient Birth Date	1251	Date Time Period	AN	1	35	Date of birth of the patient.	R	NA		Yes		CD	X	152	X	144	X		165
Patient City Name	19	City Name	AN	2	30	The city name of the patient.	R	NA		Yes		CD	X	149	X	141	X		162
Patient Condition Code	1342	Nature of Condition Code	ID	1	1	Code indicating the condition of the patient.	R	Y		No	Spinal Manip	CI-SM						X	255, 419
Patient Condition Description	352	Description	AN	1	80	Free-form description of the patient's condition.	R	NA		No	Spinal Manip	CI-SM						X	256, 420
Patient Death Date	1251	Date Time Period	AN	1	35	Date of the patient's death.	S	NA		Yes		CD						X	156
Patient Discharge Facility Type Code	1384	Patient Location Code	ID	1	1	The type of facility from which the patient was most recently discharged.	S	Y		No	Home Hlth	CI-HH	X	216					
Patient First Name	1036	Name First	AN	1	25	The first name of the individual to whom the services were provided.	R	NA		Yes		CD	X	146	X	137	X		158
Patient Gender Code	1068	Gender Code	ID	1	1	A code indicating the sex of the patient.	R	Y		Yes		CD	X	152	X	144	X		165
Patient Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the individual to whom the services were provided.	R	NA		Yes		CD	X	146	X	137	X		158, 375
Patient Middle Name	1037	Name Middle	AN	1	25	The middle name of the individual to whom the services were provided.	R	NA		Yes		CD	X	146	X	137	X		158
Patient Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the individual to whom the services were provided.	R	NA		Yes		CD	X	146	X	137	X		158
Patient Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the patient.	R	CL		Yes		CD	X	150	X	142	X		163
Patient Primary Identifier	67	Identification Code	AN	2	80	Identifier assigned by the payer to identify the patient	R	NA		No		CD	X	147	X	138	X		159
Patient Responsibility Amount	782	Monetary Amount	R	1	18	The amount determined to be the patient's responsibility for payment..	S	NA		No		CI	X	181	X	223			
Patient Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier assigned to the patient by the payer.	S	NA		No		CD	X	154	X	146	X		167
Patient Signature Source Code	1351	Patient Signature Source Code	ID	1	1	Code indication how the patient/subscriber authorization signatures were obtained and how they are being retained by the provider.	S	Y		No		CI						X	176, 345

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837- Dental	Page #	837- Professional	Page #
Patient State Code	156	State or Province Code	ID	2	2	The State Postal Code of the patient.	R	CL			Yes		CD	X	150	X	142	X	162
Patient Status Code	1352	Patient Status Code	ID	1	2	A code indicating the patient's status at the date of admission, outpatient service, or start of care.	S	Y			No		CI	X	172				
Patient Weight	81	Weight	R	1	10	Weight of the patient at time of treatment or transport.	S	NA			No		CD	X	107, 144			X	115, 156, 249, 413
Payer Additional Identifier	127	Reference Identification	AN	1	30	Additional identifier for the payer.	S	NA			No		CI	X	133	X	125	X	138
Payer Additional Name	93	Name	AN	1	60	Additional name information for the payer.	S	NA	This is only required if the name is over 35 characters.		No		CI			X	120	X	133
Payer Address Line	166	Address Information	AN	1	55	Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	NA			Yes		CI	X	129	X	121	X	134
Payer City Name	19	City Name	AN	2	30	The City Name of the Payer's claim mailing address for this particular payer ID and claim office.	S	NA			Yes		CI	X	130	X	122	X	135
Payer Identifier	67	Identification Code	AN	2	80	Number identifying the payer organization.	R	NA			Yes		CI	X	128, 491	X	118	X	131
Payer Name	1035	Name Last or Organization Name	AN	1	35	Name identifying the payer organization.	R	NA			Yes		CI	X	127	X	118	X	131, 550
Payer Paid Amount	782	Monetary Amount	R	1	18	The amount paid by the payer on this claim.	S	NA			Yes		CP			X	220	X	332
Payer Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	CL			Yes		CI	X	131	X	123	X	136
Payer Postal Zone or ZIP Code	26	Postal Code	ID	3	15	The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	CL			Yes		CI			X	123		
Payer Responsibility Sequence Number Code	1138	Payer Responsibility Sequence Number Code	ID	1	1	Code identifying the insurance carrier's level of responsibility for a payment of a claim	R	Y			No	COB	CI-COB	X	102, 360	X	99, 210	X	110, 319
Payer State Code	156	State or Province Code	ID	2	2	State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.	S	CL			Yes		CI	X	131	X	123	X	136
Pay-to Provider Additional Identifier	127	Reference Identification	AN	1	30	Additional identifer for pay-to provider.	S	NA			No		CI	X	98				
Pay-to Provider Additional Name	93	Name	AN	1	60	Additional name information for the provider to receive payment.	S	NA	This is only required if the name is over 35 characters.		No		CI			X	90	X	102
Pay-to Provider Address Line	166	Address Information	AN	1	55	Address line of the provider to receive payment	S	NA			Yes		CI	X	94	X	91	X	103
Pay-to Provider City Name	19	City Name	AN	2	30	City name of the provider to receive payment.	S	NA			Yes		CI	X	95	X	92	X	104
Pay-to Provider First Name	1036	Name First	AN	1	25	First name of the provider to receive payment.	S	NA			Yes		CI			X	88	X	100
Pay-to Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization that will receive payment.	S	NA			Yes		CI	X	93	X	89	X	101
Pay-to Provider Identifier	127	Reference Identification	AN	1	30	Identification number for the provider or organization that will receive payment.	S	NA			No		CI			X	95	X	107
Pay-to Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last or organizational name of the provider to receive payment.	S	NA			Yes		CI	X	92	X	88	X	100
Pay-to Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the pay-to provider.	S	NA			Yes		CI			X	89	X	100

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837- Institutional	Page #	837- Dental	Page #	837- Professional	Page #
Pay-to Provider Name Suffix	1039	Name Suffix	AN	1	10	The suffix, including generation, of the provider that will receive payment.	S	NA		Yes		CI			X	89	X	101
Pay-to Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the provider to receive payment	S	CL		Yes		CI	X	95	X	93	X	105
Pay-to Provider State Code	156	State or Province Code	ID	2	2	State of the provider to receive payment.	S	CL		Yes		CI	X	95	X	93	X	104
Peer Review Authorization Number	127	Reference Identification	AN	1	30	Authorization number provided by a review organization after review completed	S	NA	Peer reviews.	No		CI	X	197				
Physician Contact Date	373	Date	DT	8	8	Date of the home health agency's most recent contact with the physician.	S	NA		No	Home Hlth	CI-HH	X	215				
Physician Order Date	373	Date	DT	8	8	Date the agency received the verbal orders from the physician for start of care.	S	NA		No	Home Hlth	CI-HH	X	214				
Place of Service Code	1331	Facility Code Value	AN	1	2	The code that identifies where the service was performed.	S	Y		No		CI					X	404
Policy Compliance Code	1526	Policy Compliance Code	ID	1	2	The code that specifies policy compliance.	S	Y		No		CI-CR	X	312			X	274, 499
Policy Name	93	Name	AN	1	60	The name of the policy providing coverage.	S	NA		Yes	COB	CI-COB			X	211		
Postage Claimed Amount	782	Monetary Amount	R	1	18	Cost of postage used to provide service or to process associated paper work.	S	NA		No		CI					X	486
PPS-Capital DSH DRG Amount	782	Monetary Amount	R	1	18	PPS-capital disproportionate share amount for this claim as output by PPS-PRICER.	S	NA		No	COB	CI-COB	X	394				
PPS-Capital Exception Amount	782	Monetary Amount	R	1	18	A per discharge payment exception paid to the hospital. It is a flat-rate add-on to the PPS payment.	S	NA		No	COB	CI-COB	X	396				
PPS-Capital FSP DRG Amount	782	Monetary Amount	R	1	18	PPS-capital federal portion for this claim as output by PPS-PRICER.	S	NA		No	COB	CI-COB	X	394				
PPS-Capital HSP DRG Amount	782	Monetary Amount	R	1	18	Hospital-Specific portion for PPS-capital for this claim as output by PPS-PRICER.	S	NA		No	COB	CI-COB	X	394				
PPS-Capital IME amount	782	Monetary Amount	R	1	18	PPS-capital indirect medical expenses for this claim as output by PPS-PRICER.	S	NA		No	COB	CI-COB	X	395				
PPS-Operating Federal Specific DRG Amount	782	Monetary Amount	R	1	18	Sum of federal operating portion of the DRG amount this claim as output by PPS-PRICER.	S	NA		No	COB	CI-COB	X	395				
PPS-Operating Hospital Specific DRG Amount	782	Monetary Amount	R	1	18	Sum of hospital specific operating portion of DRG amount for this claim as output by PPS-PRICER.	S	NA		No	COB	CI-COB	X	395				
Predetermination of Benefits Identifier	127	Reference Identification	AN	1	30	Identifier or authorization number assigned to Predetermination of Benefits.	S	NA		No	Dental	CI			X	176		
Pregnancy Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A yes/no code indicating whether a patient is pregnant.	S	Y		No		CD	X	107, 144			X	116, 156
Prescription Date	1251	Date Time Period	AN	1	35	The date the prescription was issued by the referring physician.	S	NA		Yes		CI					X	200
Prescription Number	127	Reference Identification	AN	1	30	The unique identification number assigned by the pharmacy or supplier to the prescription.	S	NA		Yes		CI	X	451			X	409
Pricing Methodology	1473	Pricing Methodology	ID	2	2	Pricing methodology at which the claim or line item has been priced or repriced.	S	Y		No		CI-CR	X	309			X	272, 496
Principal Procedure Code	1271	Industry Code	AN	1	30	Code identifying the principal procedure, product or service.	S	Y		Yes		CI	X	243				
Prior Authorization Number	127	Reference Identification	AN	1	30	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization.	S	UB-92		No		CI	X	199				

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
						A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved.													
Prior Authorization or Referral Number	127	Reference Identification	AN	1	30		S	NA		No			CI					X	228, 470
Prior Placement Date	1251	Date Time Period	AN	1	35	The date of Prior Placement of the Prosthesis, Crown or Inlay, if any reason for service is replacement.	S	NA		Yes	Dental		CI			X	276		
Procedure Code	234	Product/Service ID	AN	1	48	Code identifying the procedure, product or service.	R	CL		Yes			CI	X	447, 492	X	267, 302	X	401, 498, 556
Procedure Code	1271	Industry Code	AN	1	30	Code identifying the procedure, product or service.	S	CL		No			CI	X	245-254				
Procedure Code Description	352	Description	AN	1	80	Description clarifying the Product/Service Procedure Code and related data elements.	S	NA		Yes			CI	X	492	X	303	X	557
Procedure Count	380	Quantity	R	1	15	Number of Procedures	R	NA		Yes	Dental		CI			X	270		
Procedure Date	1251	Date Time Period	AN	1	35	Date when the health care procedure was performed.	S	NA		No			CI	X	245-255				
Procedure Modifier	1339	Procedure Modifier	AN	2	2	This identifies special circumstances related to the performance of the service.	S	Y		No			CI	X	447, 448, 492	X	267, 303	X	401, 402, 556
Product or Service ID Qualifier	235	Product/Service ID Qualifier	ID	2	2	Code identifying the type/source of the descriptive number used in Product/Service ID (234).	R /S	CL /Y		No			CI	X	214, 311, 446, 491	X	266, 302	X	401, 498, 555
Prognosis Code	923	Prognosis Code	ID	1	1	Code indicating physician's prognosis for the patient.	S	Y		No		Home Hlth	CI-HH	X	211				
Property Casualty Claim Number	127	Reference Identification	AN	1	30	Identification number for property casualty claim associated with the services identified on the bill.	S	NA		No			CI	X	120, 156	X	116, 148	X	129, 169
Prosthesis, Crown, or Inlay Code"	1358	"Prosthesis, Crown or Inlay Code"	ID	1	1	Code Specifying the Placement Status for the Dental Work	S	Y		No	Dental		CI			X	270		
Provider Code	1221	Provider Code	ID	1	3	Code identifying the type of provider.	R /S	Y		No			PI	X	71, 324, 331, 338, 345, 352, 465, 472, 479, 486	X	71, 190, 198, 292	X	79, 285, 293, 504, 544
Provider or Supplier Signature Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office.	R	Y		No			CI	X	160	X	152	X	174
Provider Taxonomy Code	127	Reference Identification	AN	1	30	Code designating the provider type, classification, and specialization.	S	CL		No			PI	X	72, 325, 332, 339, 346, 353, 466, 473, 480, 487	X	72, 191, 199, 293	X	80, 286, 294, 505, 545
Purchased Service Charge Amount	782	Monetary Amount	R	1	18	The charge for the purchased service.	S	NA		No			CI					X	490
Purchased Service Provider Identifier	67	Reference Identification	AN	1	30	The provider number of the entity from which service was purchased.	S	NA		No			CI					X	300, 511
Purchased Service Provider Identifier	127						S	NA		No			CI					X	489
Purchased Service Provider Name	1035	Name Last or Organization Name	AN	1	35	The name of the provider of the purchased service.	S	NA		No			CI					X	387
Purchased Service Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider of purchased services.	S	NA		No			CI					X	302, 513
Quantity Qualifier	673	Quantity Qualifier	ID	2	2	Code specifying the type of quantity	S	Y		No			CI	X	306	X	281	X	462

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837-Institutional	Page #	837-Dental	Page #	837-Professional	Page #		
Question Number/Letter	350	Assigned Identification	AN	1	20	Identifies the question or letter number.	R	NA		No		CI				X	570			
Question Response	1073	Yes/No Condition or Response Code	ID	1	1	A yes/no question response.	S	Y		No		CI		X	167	X	570			
Question Response	127	Reference Identification	AN	1	30	A yes/no question response.	S	NA/Y		No		CI				X	571			
Question Response	332	Percent	R	1	6	A yes/no question response.	S	NA		No		CI				X	571			
Question Response	373	Date	DT	8	8	A yes/no question response.	S	NA		No		CI				X	571			
Receiver Additional Name	93	Name	AN	1	60	Additional name information for the receiver.	S	NA	This is only required if the name is over 35 characters.	No		CI		X	68	X	76			
Receiver Name	1035	Name Last or Organization Name	AN	1	35	Name of organization receiving the transaction.	R	NA		No		CI	X	68	X	67	X	75		
Receiver Primary Identifier	67	Identification Code	AN	2	80	Primary identification number for the receiver of the transaction.	R	NA		No		CI	X	68	X	67	X	75		
Reference Identification Qualifier	128	Reference Identification Qualifier	ID	2	3	Code qualifying the reference identification	R/S	Y		No		CP	X	60, 72, 83, 85, 97, 117, 120, 124, 132, 153, 155, 185, 186, 187, 189, 191, 193, 195, 197, 198, 200, 202, 325, 326, 332, 333, 339, 340, 346, 347, 353, 357, 408, 416, 418, 422, 426, 430, 434, 438, 442, 465, 467, 473, 474, 480, 481, 487, 488	X	57, 72, 84, 85, 95, 113, 115, 124, 130, 145, 147, 175, 177, 180, 182, 184, 190, 193, 199, 201, 207, 238, 247, 249, 252, 255, 259, 263, 283, 284, 285, 292, 295, 300	X	66, 80, 92, 94, 106, 126, 128, 137, 150, 166, 168, 222, 224, 226, 228, 230, 232, 233, 235, 236, 239-242, 286, 288, 294, 296, 301, 310, 316, 357, 368, 370, 373, 376, 380, 384, 388, 392, 396, 468-470, 472, 474, 475, 477-480, 483, 504, 507, 512, 521, 527, 536, 545, 547, 552	X	
Referral Date	1251	Date Time Period	AN	1	35	Date of referral.	S	NA		No		CI		X	160	X	185, 439			
Referral Number	127	Reference Identification	AN	1	30	Referral authorization number.	S	NA		No		CI		X	182, 284					
Referring CLIA Number	127	Reference Identification	AN	1	30	Referring CLIA number.	S	NA		No		CI					X	477		
Referring Provider First Name	1036	Name First	AN	1	25	The first name of provider who referred the patient to the provider of service on this claim.	S	NA		No		CI	X	343, 484	X	188	X	283, 542		
Referring Provider Identifier	67	Identification Code	AN	2	80	The identification number for the referring physician.	S	NA		No		CI	X	344	X	189	X	284, 543		
Referring Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of Provider who referred the patient to the provider of service on this claim.	S	NA		No		CI	X	343, 484	X	188	X	283, 379, 542		
Referring Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider who is referring patient for care.	S	NA		No		CI	X	344, 484	X	189	X	284, 543		
Referring Provider Name Additional Text	93	Name	AN	1	60	Additional name information identifying the referring provider.	S	NA	This is only required if the name is over 35 characters.	No		CI		X	192	X	287, 546			
Referring Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider referring the patient for care.	S	NA		No		CI	X	344, 484	X	189	X	284, 543		
Referring Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identification number for the provider referring the patient for service.	S	NA		No		CI	X	348, 489	X	194	X	289, 548		
Reimbursement Rate	954	Percent	R	1	10	Rate used when payment is based upon a percentage of applicable charges.	S	NA		No	COB	CI-COB	X	397		X	347			

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Reject Reason Code	901	Reject Reason Code	ID	2	2	Code assigned by issuer to identify reason for rejection	S	Y		No			CI-CR	X	312			X	274, 499
Related Causes Code	1362	Related-Causes Code	ID	2	3	Code identifying an accompanying cause of an illness, injury, or an accident.	R	/S	Y	No			CI	X	161, 162	X	153, 154	X	176, 177
Related Hospitalization Admission Date	1251	Date Time Period	AN	1	35	The date the patient was admitted for inpatient care related to current service.	S	NA		No			CI			X	157	X	209
Related Hospitalization Discharge Date	1251	Date Time Period	AN	1	35	The date the patient was discharged from the inpatient care referenced in the applicable hospitalization or hospice date.	S	NA		No			CI					X	211
Release of Information Code	1363	Release of Information Code	ID	1	1	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.	R	Y		No			CI	X	161, 391	X	153, 230	X	175, 345
Remark Code	127	Reference Identification	AN	1	30	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list.	S	Y		No		COB	CI-COB	X	393, 396, 398, 399			X	348, 349
Rendering Provider First Name	1036	Name First	AN	1	25	The first name of the provider who performed the service.	S	NA		Yes			PI			X	196, 290	X	291, 502
Rendering Provider Identifier	67	Identification Code	AN	2	80	The identifier assigned by the Payor to the provider who performed the service.	S	NA		Yes			PI			X	197, 291	X	292, 503
Rendering Provider Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The last name or organization of the provider who performed the service	S	NA		Yes			PI			X	196, 290	X	291, 383, 502
Rendering Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider who has provided the services to the patient.	S	NA		Yes			PI			X	196, 290	X	292, 503
Rendering Provider Name Additional Text	93	Name	AN	1	60	Additional name information identifying the rendering provider.	S	NA		No			PI			X	200, 294	X	295, 506
Rendering Provider Name Suffix	1039	Name Suffix	AN	1	10	Name suffix of the provider who has provided the services to the patient.	S	NA		Yes			PI			X	196, 290	X	292, 503
Rendering Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider providing care to the patient.	S	NA		Yes			PI			X	202, 296	X	297, 508
Replacement Date	1251	Date Time Period	AN	1	35	Replacement Date for appliance or prosthesis	S	NA		No		Dental	CI			X	280		
Repriced Allowed Amount	782	Monetary Amount	R	1	18	The maximum amount determined by the repricer as being allowable under the provisions of the contract prior to the determination of the actual payment.	S	NA		No			CI-CR	X	309			X	272, 496
Repriced Approved Ambulatory Patient Group Amount	782	Monetary Amount	R	1	18	Amount of payment by the repricer for the referenced Ambulatory Patient Group.	S	NA		No			CI-CR					X	273, 497
Repriced Approved Ambulatory Patient Group Code	127	Reference Identification	AN	1	30	Identifier for Ambulatory Patient Group assigned to the claim by the repricer.	S	M		No			CI-CR					X	273, 497
Repriced Approved Amount	782	Monetary Amount	R	1	18	The amount allowed by the repricer for the claim or service line net of adjustments.	S	NA		No			CI-CR	X	310				
Repriced Approved DRG Code	127	Reference Identification	AN	1	30	The Diagnosis Related Group approved by the repricer for payment for this claim	S	CL		No			CI-CR	X	310				
Repriced Approved HCPCS Code	234	Product/Service ID	AN	1	48	The HCPCS code that describes the services as approved by the repricer.	S	CL		No			CI-CR	X	311				
Repriced Approved Revenue Code	234	Product/Service ID	AN	1	48	UB92 revenue code approved by the repricer for payment on the claim.	S	CL		No			CI-CR	X	311				

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837- Institutional	Page #	837- Dental	Page #	837- Professional	Page #
Repriced Approved Service Unit Count	380	Quantity	R	1	15	Number of service units approved by pricing or repricing entity.	S	NA		No		CI-CR	X	312			X	499
Repriced Claim Reference Number	127	Reference Identification	AN	1	30	Identification number, assigned by a repricing organization, to identify the claim.	S	NA		No		CI-CR	X	186			X	233
Repriced Line Item Reference Number	127	Reference Identification	AN	1	30	Identification number of a line item repriced by a third party or prior payer.	S	NA		No		CI-CR					X	468
Repriced Saving Amount	782	Monetary Amount	R	1	18	The amount of savings related to Third Party Organization claims.	S	NA		No		CI-CR	X	310			X	273, 497
Repricing Organization Identifier	127	Reference Identification	AN	1	30	Reference or identification number of the repricing organization.	S	NA		No		CI-CR	X	310			X	273, 497
Repricing Per Diem or Flat Rate Amount	118	Rate	R	1	9	Amount used to determine the flat rate or per diem price by the repricing organization.	S	NA		No		CI-CR	X	310			X	273, 497
Responsible Party Additional Name	93	Name	AN	1	60	Additional name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	S	NA	This is only required if the name is over 35 characters.	No		CI					X	142
Responsible Party Address Line	166	Address Information	AN	1	55	Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes		CI	X	136			X	143
Responsible Party City Name	19	City Name	AN	2	30	City name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes		CI	X	137			X	144
Responsible Party First Name	1036	Name First	AN	1	25	First name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes		CI	X	135			X	140
Responsible Party Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes		CI	X	135			X	140
Responsible Party Middle Name	1037	Name Middle	AN	1	25	Middle name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes		CI	X	135			X	141
Responsible Party Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	CL		Yes		CI	X	137			X	145
Responsible Party State Code	156	State or Province Code	ID	2	2	State or province of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations.	R	CL		Yes		CI	X	137			X	144
Responsible Party Suffix Name	1039	Name Suffix	AN	1	10	Suffix for name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes		CI	X	135			X	141
Round Trip Purpose Description	352	Description	AN	1	80	Free-form description of the purpose of the ambulance transport round trip.	S	NA		No	Ambulance	CI					X	250, 414

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Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837- Institutional	Page #	837-Dental	Page #	837- Professional	Page #
Sales Tax Amount	782	Monetary Amount	R	1	18	Amount of sales tax attributable to the referenced Service.	S	NA		No		CI					X	484
Service Adjudication or Payment Date	1251	Date Time Period	AN	1	35	Date of payment or denial determination by previous payer when service line adjudication has been performed.	S	NA		No		CP	X	502				
Service Authorization Exception Code	127	Reference Identification	AN	1	30	Code identifying the service authorization exception.	S	Y	Required when a service is provided without required prior authorization.	No		CI	X	196	X	178	X	223
Service Date	373	Date Time Period	AN	1	35	Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.	R /S	NA		Yes		CI	X	457	X	165, 274	X	436
Service Facility Location Secondary Identifier	127	Reference Identification	AN	1	30	Secondary identifier for service facility location.	S	NA		No		CI					X	522
Service Facility Name	1035	Name Last or Organization Name	AN	1	35	Name for sevice facility.	S	NA		Yes		CI					X	391
Service From Date	373	Date	DT	8	8	The date the service referenced in the claim or service line was initiated.	S	NA		No	Home Hlth	CI-HH	X	211				
Service Line Paid Amount	782	Monetary Amount	R	1	18	Amount paid by the indicated payer for a service line	S	NA		No		CP	X	491	X	302	X	555
Service Line Rate	1371	Unit Rate	R	1	10	Payment rate that applies to the service line.	S	NA		No		CI	X	449				
Service Line Revenue Code	234	Product/Service ID	AN	1	48	UB92 Revenue Code pertaining to the service line.	R	CL		No		CI	X	446, 492				
Service Tax Amount	782	Monetary Amount	R	1	18	The amount of service tax or surcharge applicable to the reported service	S	NA		No		CI	X	460				
Service Unit Count	380	Quantity	R	1	15	The quantity of units, times, days, visits, services, or treatments for the service described by the HCPCS codes, revenue code or procedure code.	R	NA		Yes		CI	X	449			X	403
Ship, Delivery or Calendar Pattern Code"	678	Ship/Delivery or Calendar Pattern Code	ID	1	2	The time delivery pattern for the services.	S	Y		No	Home Hlth	CI-HH	X	318			X	280, 493
Shipped Date	1251	Date Time Period	AN	1	35	Date product shipped.	S	NA		No		CI					X	451
Similar Illness or Symptom Date	1251	Date Time Period	AN	1	35	Date of onset of a similar illness or symptom.	S	NA		No		CI					X	193, 461
Skilled Nursing Facility Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Code indicating whether or not a patient is receiving care in a 1861J1 (skilled nursing) facility	S	Y		No	Home Hlth	CI-HH	X	212				
Special Program Indicator	1366	Special Program Code	ID	2	3	A code indicating the Special Program under which the services rendered to the patient were performed.	S	Y		No		CI	X	163	X	155	X	178
Statement From or To Date	1251	Date Time Period	AN	1	35	The date of the start or end of the period covered on the claim.	R	NA		No		CI	X	168				
Stretcher Purpose Description	352	Description	AN	1	80	Free-form description of the purpose of the use of a stretcher during ambulance service.	S	NA		No	Ambulan ce	CI					X	250, 414
Student Status Code	1220	Student Status Code	ID	1	1	Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured	S	Y		No	Dental Spinal Manip	CD			X	135		
Subluxation Level Code	1367	Subluxation Level Code	ID	2	3	Code identifying the specific level of subluxation.	S	Y		No		CI-SM					X	252, 253, 416, 417
Submitter Contact Name	93	Name	AN	1	60	Name of the person at the submitter organization to whom inquiries about the transaction should be directed.	R	NA		No		PI	X	65	X	64	X	72

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All data elements - in order by Industry Name				FIELD LENGTH										Implementation Guide		Implementation Guide		Implementation Guide	
Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition	Required or Situati	In Impl'tn Guide	Commentary	Currently captured by DMH	Service	Client, Provider, or Claim Data	837-Institutional	Page #	837-Dental	Page #	837-Professional	Page #	
Submitter First Name	1036	Name First	AN	1	25	The first name of the person submitting the transaction or receiving the transaction, as identified by the preceding identification code.	S	NA		Yes		PI	X	62	X	60	X	68	
Submitter Identifier	67	Identification Code	AN	2	80	Code or number identifying the entity submitting the claim.	R	M		No		PI	X	63	X	61	X	69	
Submitter Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The last name or the organizational name of the entity submitting the transaction	R	NA		Yes		PI	X	62	X	60	X	68	
Submitter Middle Name	1037	Name Middle	AN	1	25	The middle name of the person submitting the transaction	S	NA		Yes		PI	X	62	X	60	X	68	
Subscriber Address Line	166	Address Information	AN	1	55	Address line of the current mailing address of the insured individual or subscriber to the coverage.	S	NA		Yes	COB	CI-COB	X	112	X	108	X	121	
Subscriber Birth Date	1251	Date Time Period	AN	1	35	The date of birth of the subscriber to the indicated coverage or policy.	S	NA		Yes	COB	CI-COB	X	116	X	112	X	125	
Subscriber City Name	19	City Name	AN	2	30	The City Name of the insured individual or subscriber to the coverage	S	NA		Yes	COB	CI-COB	X	113	X	109	X	122	
Subscriber First Name	1036	Name First	AN	1	25	The first name of the insured individual or subscriber to the coverage		NA		Yes	COB	CI-COB	X	109	X	104	X	118	
Subscriber Gender Code	1068	Gender Code	ID	1	1	Code indicating the sex of the subscriber to the indicated coverage or policy.		Y		Yes	COB	CI-COB	X	116	X	112	X	125	
Subscriber Last Name	1035	Name Last or Organization Name	AN	1	35	The surname of the insured individual or subscriber to the coverage	R	NA		Yes	COB	CI-COB	X	109	X	104	X	118	
Subscriber Middle Name	1037	Name Middle	AN	1	25	The middle name of the subscriber to the indicated coverage or policy.	S	NA		Yes	COB	CI-COB	X	109	X	104	X	118	
Subscriber Name Suffix	1039	Name Suffix	AN	1	10	Suffix of the insured individual or subscriber to the coverage.	S	NA		Yes	COB	CI-COB	X	110	X	105	X	118	
Subscriber Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the insured individual or subscriber to the coverage	S	CL		Yes	COB	CI-COB	X	114	X	110	X	123	
Subscriber Primary Identifier	67	Identification Code	AN	2	80	Primary identification number of the subscriber to the coverage.	R /S	NA		Yes	COB	CI-COB	X	110	X	106	X	119	
Subscriber State Code	156	State or Province Code	ID	2	2	The State Postal Code of the insured individual or subscriber to the coverage	S	CL		Yes	COB	CI-COB	X	114	X	110	X	123	
Subscriber Supplemental Description	93	Name	AN	1	60	Text information clarifying subscriber additional information	S	NA	This is only required if the name is over 35 characters.	No	COB	CI-COB			X	107	X	120	
Subscriber Supplemental Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the subscriber.	S	NA		No	COB	CI-COB	X	118	X	114	X	127	
Supervising Provider First Name	1036	Name First	AN	1	25	The First Name of the Provider who supervised the rendering of a service on this claim.	S	NA		No		PI					X	313, 524	
Supervising Provider Identifier	67	Identification Code	AN	2	80	The Identification Number for the Supervising Provider.	S	NA		No		PI					X	314, 525	
Supervising Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of the Provider who supervised the rendering of a service on this claim.	S	NA		No		PI					X	313, 395, 524	
Supervising Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider supervising care rendered to the patient.	S	NA		No		PI					X	313, 524	
Supervising Provider Name Additional Text	93	Name	AN	1	60	Additional name information of the provider supervising care rendered to the patient.	S	NA	This is only required if the name is over 35 characters.	No		PI					X	315, 526	
Supervising Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider supervising care rendered to the patient.	S	NA		No		PI					X	313, 524	
Supervising Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider supervising care rendered to the patient.	S	NA		No		PI					X	317	

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All data elements - in order by Industry Name						FIELD LENGTH		Required or Situat'l In Impl'n Guide	Commentary	Currently captured by DMH	Service	Client, Provider, or Claim Data	Implementation Guide		Implementation Guide		Implementation Guide	
Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition							837 - Institutional	Page #	837 - Dental	Page #	837 - Professional	Page #
Surgery Date	373	Date	DT	8	8	Requested, anticipated, or actual date of surgery.	S	NA		No	Home Hlth	CI-HH	X	213				
Surgical Procedure Code	1137	Medical Code Value	AN	1	15	Code describing the surgical procedure most relevant to the care being rendered.	S	CL		No	Home Hlth	CI-HH	X	214				
Terms Discount Percentage	338	Terms Discount Percent	R	1	6	Discount percentage available to the payer for payment within a specific time period.	S	NA		No		CI	X	177			X	218
Test Performed Date	1251	Date Time Period	AN	1	35	The date the patient was tested for arterial blood. gas and/or oxygen saturation on room air.	S	NA		No		CI					X	448
Test Results	739	Measurement Value	R	1	20	If tests are performed under other conditions such as oxygen, give test results and information necessary for interpreting the tests and why performed under these conditions.	S	NA		No		CI					X	465
Tooth Code	1271	Industry Code	AN	1	30	An indication of the tooth on which services were performed or will be performed.	S	CL		Yes	Dental	CI			X	272		
Tooth Number	127	Reference Identification	AN	1	30	Standard identification number of a tooth.	S	CL		Yes	Dental	CI			X	168		
Tooth Status Code	1368	Tooth Status Code	ID	1	2	Code specifying the status of a tooth	S	Y		Yes	Dental	CI			X	168		
Tooth Surface Code	1369	Tooth Surface Code	ID	1	2	The surface(s) of the tooth on which services were performed or will be performed.	S	Y		Yes	Dental	CI			X	272		
Total Claim Charge Amount	782	Monetary Amount	R	1	18	The sum of all charges included within this claim.	R	NA		No		CP	X	159	X	151	X	172
Total Medicare Paid Amount	782	Monetary Amount	R	1	18	Amount reported by the payer as paid by Medicare	S	NA		No	COB	CI-COB	X	377				
Total Purchased Service Amount	782	Monetary Amount	R	1	18	Amount of charges associated with the claim attributable to purchased services	S	NA	Pertains to subcontracted services.	No		CI					X	221
Total Visits Projected This Certification Count	1470	Number	N0	1	9	Total covered visits to be rendered by each discipline during the period covered by the plan of treatment, including PRN visits.	S	NA		No	Home Hlth	CI-HH	X	315				
Total Visits Rendered Count	1470	Number	N0	1	9	Total visits on this bill rendered prior to re-certification date.	S	NA		No	Home Hlth	CI-HH					X	277
Transaction Segment Count	96	Number of Included Segments	N0	1	10	A tally of all segments between the ST and the SE segments including the ST and SE segments.	R	NA		No		CP	X	503	X	313	X	572
Transaction Set Control Number	329	Transaction Set Control Number	AN	4	9	The unique identification number within a transaction set.	R	NA		No		CP	X	56, 503	X	53, 313	X	62, 572
Transaction Set Creation Date	373	Date	DT	8	8	Identifies the date the submitter created the transaction	R	NA		No		CP	X	58	X	55	X	64
Transaction Set Creation Time	337	Time	TM	4	8	Time file is created for transmission.	R	NA		No		CP	X	58	X	56	X	65
Transaction Set Identifier Code	143	Reference Identification	AN	1	30	Code uniquely identifying a Transaction Set.	R	Y		No		CP	X	56	X	53	X	62
Transaction Set Purpose Code	353	Transaction Set Purpose Code	ID	2	2	Code identifying purpose of transaction set.	R	Y		No		CP	X	58	X	55	X	64
Transmission Type Code	127	Reference Identification	AN	1	30	Code identifying the type of transaction or transmission included in the transaction set.	R	Y		No		CP	X	60	X	57	X	66
Transport Distance	380	Quantity	R	1	15	Distance traveled during the ambulance transport.	S	NA		No	Ambulan ce	CI					X	250, 414
Treatment Code	1271	Industry Code	AN	1	30	Code identifying treatment according to treatment code list instructions as determined according to uniform bill instructions	S	Y		No	Home Hlth	CI-HH	X	300-305				
Treatment Count	380	Quantity	R	1	15	Total number of treatments in the series.	S	NA		No	Spinal Manip	CI-SM					X	252, 416
Treatment Period Count	380	Quantity	R	1	15	The number of time periods during which treatment will be provided to patient.	S	NA		No	Spinal Manip	CI-SM					X	255, 419, 424

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All data elements - in order by Industry Name					FIELD LENGTH			Required or Situat'l	In Impl'n Guide	Commentary	Currently captured by DMH	Service	Client, Provider, or Claim Data	Implementation Guide		Implementation Guide		Implementation Guide	
Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition								837- Institutional	Page #	837- Dental	Page #	837- Professional	Page #
Treatment Series Number	609	Count	N0	1	9	Number this treatment is in the series of services.	S	NA		No	Spinal Manip	CI-SM					X	252, 416	
Unit or Basis for Measurement Code	355	Unit or Basis for Measurement Code	ID	2	2	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	S	Y		No		CI	X	107, 144, 307, 311, 448			X	115, 156, 249, 250, 254, 403, 413, 414, 418, 422, 498	
Universal Product Number	127	Reference Identification	AN	1	30	Industry standard code identifying supplies and materials.	S	NA		No		CI					X	483	
Value Added Network Trace Number	127	Reference Identification	AN	1	30	Unique Identification number for a transaction assigned by a Value Added Network, Clearinghouse, or other transmission entity.	S	NA		No		CP	X	188	X	184			
Value Code	1271	Industry Code	AN	1	30	The uniform billing value code communicating established billing information.	S	CL		No		CI	X	281-288					
Value Code Associated Amount	782	Monetary Amount	R	1	18	Amount associated with indicated code value	S	NA		No		CI	X	281-289					
Visits	673	Quantity Qualifier	ID	2	2	The unit for home health visitations. Example: One visit every three days for 21 days. This element qualifies that the data is communicating visits.	S	NA		No	Home Hlth	CI-HH	X	317			X	279, 492	
Visits Prior to Recertification Date Count	1470	Number	N0	1	9	Number of visits for care prior to the date of the recertification of services.	S	NA		No	Home Hlth	CI-HH	X	315					
Work Return Date	1251	Date Time Period	AN	1	35	Date patient was or is able to return to the patient's normal occupation or to a similar or substitute occupation.	S	NA		No		CI					X	207	
X-ray Availability Indicator	1073	Response Code	ID	1	1	Indicates if X-Rays are on file for chiropractor spinal manipulation.	S	Y		No	Spinal Manip	CI-SM					X	256, 420	

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837-Institutional Data Elements						FIELD LENGTH		Required or Situati'	In Impl'tn Guide		Currently captured by DMH	Service
Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition						
Activities Permitted Code	1321	Condition Indicator	ID	2	2	Code describing the activities permitted by the physician or for which physician's orders are present.		S	Y		No	
Adjudication or Payment Date	1251	Date Time Period	AN	1	35	Date of payment or denial determination by previous payer.		S	NA		No	
Adjusted Repriced Claim Reference Number	127	Reference Identification	AN	1	30	Identification number, assigned by a repricing organization, to identify an adjusted claim.		S	NA		No	
Adjustment Amount	782	Monetary Amount	R	1	18	Adjustment amount for the associated reason code.		R	NA		No	
Adjustment Quantity	380	Quantity	R	1	15	Numeric quantity associated with the related reason code for coordination of benefits.		R	NA		No	
Adjustment Reason Code	1034	Claim Adjustment Reason Code	ID	1	5	Code that indicates the reason for the adjustment.		R	CL		No	
Admission Date and Hour	1251	Date Time Period	AN	1	35	The date and time of the admission to the facility.		R	NA	The date is mandatory in CTRAC, but the time of admission is optional in CTRAC, but both are now required under HIPAA.	Yes/No	
Admission Source Code	1314	Admission Source Code	ID	1	1	Code indicating the source of this admission.		S	CL		No	
Admission Type Code	1315	Admission Type Code	ID	1	1	Code indicating the priority of this admission.		S	CL	A field by this same name is mandatory in CTRAC, but it has different contents and purpose. This data is required under HIPAA when the patient is being admitted to the hospital for inpatient services.	No	
Allowed Amount	782	Monetary Amount	R	1	18	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment.		R	NA		No	COB
Amount Qualifier Code	522	Amount Qualifier Code	ID	1	3	Code to qualify amount.		S	Y		No	
Assessment Date	1251	Date Time Period	AN	1	35	Date on which patient assessment or other required assessment was performed		S	NA		Yes	

Assigned Number	554	Assigned Number	N0	1	6	Number assigned for differentiation within a transaction set.	R	NA		No	
Attachment Control Number	67	Identification Code	AN	2	80	Identification number of attachment related to the claim.	S	M	Needed if there are paper attachments to a claim.	No	
Attachment Description	352	Description	AN	1	80	Free-form text describing attachments related to the claim.	S	NA	Needed if there are paper attachments to a claim.	No	
Attachment Report Type Code	755	Report Type Code	ID	2	2	Code to specify the type of attachment that is related to the claim.	S	Y	Needed if there are paper attachments to a claim.	No	
Attachment Transmission Code	756	Report Transmission Code	ID	1	2	Code defining timing, transmission method or format by which an attachment report is to be sent or has been sent.	S	Y	Needed if there are paper attachments to a claim.	No	
Attending Physician First Name	1036	Name First	AN	1	25	First name of the physician responsible for care of the patient.	S	NA		Yes	
Attending Physician Last Name	1035	Name Last or Organization Name	AN	1	35	Last name of the physician responsible for care of the patient.	S	NA		Yes	
Attending Physician Middle Name	1037	Name Middle	AN	1	25	Middle name of the physician responsible for care of the patient	S	NA		Yes	
Attending Physician Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the physician responsible for the care of the patient	S	NA		Yes	
Attending Physician Primary Identifier	67	Identification Code	AN	2	80	Primary identification number of the physician responsible for care of the patient.	S	NA		Yes	
Attending Physician Secondary Identifier	127	Reference Identification	AN	1	30	Secondary identification number of the physician responsible for the care of the patient	S	NA		Yes	
Auto Accident State or Province Code	156	State or Province Code	ID	2	2	State or Province where auto accident occurred.	S	CL		No	
Benefits Assignment Certification Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.	R	Y		No	COB
Billing Note Text	352	Description	AN	1	80	Free-form text providing additional information about the bill or claim being submitted.	S	NA		No	
Billing Provider Additional Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the billing provider	S	NA		No	
Billing Provider Address Line	166	Address Information	AN	1	55	Address line of the billing provider or billing entity address.	R	NA		Yes	
Billing Provider City Name	19	City Name	AN	2	30	City of the billing provider or billing entity	R	NA		Yes	
Billing Provider Contact Name	93	Name	AN	1	60	Person at billing organization to contact regarding the billing transaction.	S	NA		No	
Billing Provider Credit Card Identifier	127	Reference Identification	AN	1	30	Identification number for credit card processing for the billing provider or billing entity	S	NA		No	
Billing Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.	R	NA		Yes	
Billing Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the provider billing or billing entity for services.	R	NA		Yes	
Billing Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal zone code or ZIP code for the provider or billing entity billing for services.	R	CL		Yes	
Billing Provider State or Province Code	156	State or Province Code	ID	2	2	State or province for provider or billing entity billing for services.	R	CL		Yes	

Bundled or Unbundled Line Number	554	Assigned Number	NO	1	6	Identification of line item bundled or unbundled by payer in coordination of benefits.	S			No	
Certification Condition Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Code indicating whether or not the condition codes apply to the patient or another entity.	S			No	
Certification Condition Indicator	1136	Code Category	ID	2	2	Code indicating whether or not the condition codes apply to the patient or another entity.	S			No	
Certification Type Code	1322	Certification Type Code	ID	1	1	Code indicating the type of certification	S	Y		No	
Claim Adjustment Group Code	1033	Claim Adjustment Group Code	ID	1	2	Code identifying the general category of payment adjustment.	S	Y		No	
Claim Days Count	380	Quantity	R	1	15	The number of categorized days associated with the claim, such as lifetime reserve days, covered days.	S	NA		No	
Claim Disproportionate Share Amount	782	Monetary Amount	R	1	18	Sum of operating capital disproportionate share amounts for this claim.	S	NA		No	M'care inpatient
Claim DRG Amount	782	Monetary Amount	R	1	18	Total of Prospective Payment System operating and capital amounts for this claim.	S	NA		No	M'care inpatient
Claim DRG Outlier Amount	782	Monetary Amount	R	1	18	Total Prospective Payment System Outlier and Capital Outlier amounts for this claim.	S	NA		No	DRG
Claim ESRD Payment Amount	782	Monetary Amount	R	1	18	End Stage Renal Disease (ESRD) payment amount for the claim.	S	NA		No	M'care outpatient
Claim Filing Indicator Code	1032	Claim Filing Indicator Code	ID	1	2	Code identifying type of claim or expected adjudication process.	S	Y		No	COB
Claim Frequency Code	1325	Claim Frequency Type Code	ID	1	1	Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.	R	M		No	
Claim HCPCS Payable Amount	782	Monetary Amount	R	1	18	Sum of payable line item amounts for HCPCS codes billed on this claim.	S	NA		No	M'care outpatient
Claim Indirect Teaching Amount	782	Monetary Amount	R	1	18	Total of operating and capital indirect teaching amounts for this claim.	S	NA		No	M'care inpatient
Claim MSP Pass-through Amount	782	Monetary Amount	R	1	18	Interim cost pass-through amount used to determine Medicare Secondary Payer liability.	S	NA		No	M'care inpatient
Claim Note Text	352	Description	AN	1	80	Narrative text providing additional information related to the claim.	S	NA	This is for when you need to note additional information.	No	
Claim or Encounter Identifier	640	Transaction Type Code	ID	2	2	Code indicating whether the transaction is a claim or reporting encounter information.	R	Y		No	
Claim Original Reference Number	127	Reference Identification	AN	1	30	Number assigned by a processor to identify a claim.	S	NA		No	
Claim PPS Capital Amount	782	Monetary Amount	R	1	18	Total Prospective Payment System (PPS) capital amount payable for this claim as output by PPS PRICER.	S	NA		No	M'care inpatient
Claim PPS Capital Outlier Amount	782	Monetary Amount	R	1	18	Total Prospective Payment System capital day or cost outlier payable for this claim, excluding operating outlier amount.	S	NA		No	M'care inpatient

Claim Total Denied Charge Amount	782	Monetary Amount	R	1	18	Total amount of charges that were denied for this claim.	S	NA		No	COB
Code Category	1136	Code Category	ID	2	2	Specifies the situation or category to which the code applies.	S	Y		No	
Code List Qualifier Code	1270	Code List Qualifier Code	ID	1	3	Code identifying a specific industry code list.	R	Y		No	
Communication Number	364	Communication Number	AN	1	80	Complete communications number including country or area code when applicable	R	NA	This is the biller's phone/fax/e-mail/edi number.	Yes	
Communication Number Qualifier	365	Communication Number Qualifier	ID	2	2	Code identifying the type of communication number	R	Y		No	
Condition Code	1271	Industry Code	AN	1	30	Code(s) used to identify condition(s) relating to this bill or relating to the patient.	S	M		No	
Contact Function Code	366	Contact Function Code	ID	2	2	Code identifying the major duty or responsibility of the person or group named.	R	Y		No	
Contract Amount	782	Monetary Amount	R	1	18	Fixed monetary amount pertaining to the contract	S	NA		Yes	
Contract Code	127	Reference Identification	AN	1	30	Code identifying the specific contract, established by the payer.	S	M		No	
Contract Percentage	332	Percent	R	1	6	Percent of charges payable under the contract	S	NA		No	
Contract Type Code	1166	Contract Type Code	ID	2	2	Code identifying a contract type	S	Y		No	
Contract Version Identifier	799	Version Identifier	AN	1	30	Identification of additional or supplemental contract provisions, or identification of a particular version or modification of contract.	S	M		No	
Coordination of Benefits Total Submitted Charge Amount	782	Monetary Amount	R	1	18	The total coordination of benefit charges submitted applicable to the claim.	S	NA		Yes	COB
Cost Report Day Count	380	Quantity	R	1	15	The number of days that may be claimed as Medicare patient days on a cost report.	S	NA		Yes	M'care inpatient
Country Code	26	Country Code	ID	2	3	Code indicating the geographic location.	S	CL	This is required when the biller's address is outside the United States.	No	
Covered Days or Visits Count	380	Quantity	R	1	15	Number of days or visits covered by the primary payer or days/visits that would have been covered had Medicare been primary.	S	NA	Medicare lifetime reserve day count.	No	M'care inpatient
Credit or Debit Card Authorization Number	127	Reference Identification	AN	1	30	Credit/Debit card authorization number used to authorize use of card for payment for billed charges.	S	NA		No	
Credit or Debit Card Holder First Name	1036	Name First	AN	1	25	First name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Holder Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB

Credit or Debit Card Holder Middle Name	1037	Name Middle	AN	1	25	Middle name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Holder Name Suffix	1039	Name Suffix	AN	1	10	Name suffix of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Maximum Amount	782	Monetary Amount	R	1	18	Dollar limit for a credit or debit card	S	NA		No	COB
Credit or Debit Card Number	67	Identification Code	AN	2	80	Credit/Debit card number that may be used to pay for billed charges.	S	NA		No	COB
Currency Code	100	Currency Code	ID	3	3	Code for country in whose currency the charges are specified.	S	CL	Only needed for foreign currency.	No	
Date Time Period	1251	Date Time Period	AN	1	35	Expression of a date, a time, or a range of dates, times, or dates and times.	S	Y		No	
Date Time Period Format Qualifier	1250	Date Time Period Format Qualifier	ID	2	3	Code indicating the date format, time format, or date and time format	S	Y	Required when the patient is the same as the subscriber.	No	
Date Time Qualifier	374	Date/Time Qualifier	ID	3	3	Code specifying the type of date or time or both date and time.	S	Y		No	
Delay Reason Code	1514	Delay Reason Code	ID	1	2	Code indicating the reason why a request was delayed.	S	Y		No	
Delivery Pattern Time Code	679	Ship/Delivery Pattern Time Code	ID	1	1	Code which specifies the time delivery pattern of the services..	S	Y		No	Home Hlth
Demonstration Project Identifier	127	Reference Identification	AN	1	30	Identification number for a Medicare demonstration project.	S	Y/NA		No	Demo Projects
Diagnosis Date	373	Date	DT	8	8	Date the diagnosis was established or recorded.	S	NA		No	Home Hlth
Diagnosis Related Group (DRG) Code	1271	Industry Code	AN	1	30	Diagnosis related group for this claim.	S	M		No	
Discharge Hour	1251	Date Time Period	AN	1	35	Hour that the patient was discharged from inpatient care.	S	NA		No	
Discipline Type Code	921	Discipline Type Code	ID	2	2	Code indicating discipline(s) ordered by the physician.	S	Y		No	Home Hlth
Document Control Identifier	127	Reference Identification	AN	1	30	Internal control number assigned by a payer to facilitate retrieval or association of a claim.	S	NA		No	
Duration of Visits Units	615	Time Period Qualifier	ID	1	2	The unit (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit every three days occurs over a duration of days.	S	NA		No	Home Hlth

Duration of Visits, Number of Units	616	Number of Periods	NO	1	3	The number of units (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit every three days occurs over a duration of days.	S	NA		No	Home Hlth
Entity Identifier Code	98	Entity Identifier Code	ID	2	3	Code identifying an organizational entity, a physical location, property or an individual	R	Y		No	
Entity Type Qualifier	1065	Entity Type Qualifier	ID	1	1	Code qualifying the type of entity	R	Y		No	
Estimated Claim Due Amount	782	Monetary Amount	R	1	18	The amount estimated by the provider to be due from the payer.	S	NA		No	
Exception Code	1527	Exception Code	ID	1	2	Exception code generated by the Third Party Organization.	S	Y		No	
Explanation of Benefits Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Indicator of whether a paper explanation of benefits (EOB) is requested.	R	Y		No	
Facility Code Qualifier	1332	Facility Code Qualifier	ID	1	2	Code identifying the type of facility referenced.	R	Y		No	
Facility Tax Amount	782	Monetary Amount	R	1	18	The amount of facility tax or surcharge applicable to the reported service	S	NA		No	
Facility Type Code	1331	Facility Code Value	AN	1	2	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.	R	Y		No	
Fixed Format Information	449	Fixed Format Information	AN	1	80	Data in fixed format agreed upon by sender and receiver	S	NA	Not used at this time.	No	
Frequency Count	1167	Sample Selection Modulus	R	1	6	The count of the frequency units of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit occurs at three day intervals.	S	NA		No	Home Hlth
Frequency Period	355	Unit or Basis for Measurement Code	ID	2	2	The units specifying the frequency of home health visits (e.g., days, months, etc.) Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit occurs at a frequency of days.	S	NA		No	Home Hlth
Functional Limitation Code	1073	Condition Indicator	ID	2	2	Code describing the patient's functional limitations as assessed by the physician.	S	Y		No	Home Hlth
Functional Limitation Code	1321	Condition Indicator	ID	2	2	Code describing the patient's functional limitations as assessed by the physician.	S	Y		No	Home Hlth
Hierarchical Child Code	736	Hierarchical Child Code	ID	1	1	Code indicating if there are hierarchical child data segments subordinate to the level being described.	R	Y		No	

Hierarchical ID Number	628	Hierarchical ID Number	AN	1	12	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.	R	NA		No	
Hierarchical Level Code	735	Hierarchical Level Code	ID	1	2	Code defining the characteristic of a level in a hierarchical structure.	R	Y		No	
Hierarchical Parent ID Number	734	Hierarchical Parent ID Number	AN	1	12	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.	R	NA		No	
Hierarchical Structure Code	1005	Hierarchical Structure Code	ID	4	4	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	R	Y		No	
Home Health Certification Period	1251	Date Time Period	AN	1	35	Certification period for home health care covered by this plan of treatment.	S	NA		No	Home Hlth
Identification Code Qualifier	66	Identification Code Qualifier	ID	1	2	Code designating the system/method of code structure used for Identification Code (67)	R	Y		No	
Individual Relationship Code	1069	Individual Relationship Code	ID	2	2	Code indicating the relationship between two individuals or entities			Differs from the information in CTRAC	No	
Industry Code	1271	Industry Code	AN	1	30	Code indicating a code from a specific industry code list.				No	
Information Receiver Identification Number	66	Identification Code Qualifier	ID	1	2	The identification number of the individual or organization who expects to receive information in response to a query.	R	Y		No	
Insured Group Name	93	Name	AN	1	60	Name of the group or plan through which the insurance is provided to the insured.	S	NA		Yes	COB
Insured Group or Policy Number	127	Identification Code	AN	2	80	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	S	NA		No	COB
Investigational Device Exemption Identifier	127	Reference Identification	AN	1	30	Number or reference identifying exemption assigned to an investigational device referenced in the claim.	S	NA		No	
Laboratory or Facility Address Line	166	Address Information	AN	1	55	Address line of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	NA		Yes	
Laboratory or Facility City Name	19	City Name	AN	2	30	City of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	NA		Yes	
Laboratory or Facility Name	1035	Name Last or Organization Name	AN	1	35	Name of laboratory or other facility performing Laboratory testing on the claim where the health care service was performed/rendered.	R	NA		Yes	
Laboratory or Facility Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP or zonal code of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	CL		Yes	
Laboratory or Facility Primary Identifier	67	Identification Code	AN	2	80	Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.	R	NA		No	

Laboratory or Facility Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	S	NA		No	
Laboratory or Facility State or Province Code	156	State or Province Code	ID	2	2	State or province of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	CL		Yes	
Last Admission Period	1251	Date Time Period	AN	1	35	Admission date of the most recent inpatient stay.	S	NA		No	Home Hlth
Last Visit Date	373	Date	DT	8	8	Date the patient was last seen by the physician.	S	NA		No	Home Hlth
Lifetime Psychiatric Days Count	380	Quantity	R	1	15	Number of lifetime psychiatric days used for this claim.	S	NA		No	M'care inpatient
Lifetime Reserve Days Count	380	Quantity	R	1	15	Number of lifetime reserve days used for this claim.	S	NA		No	M'care inpatient
Line Item Charge Amount	782	Monetary Amount	R	1	18	Charges related to this service.	R	NA		No	
Line Item Denied Charge or Non-Covered Charge Amount	782	Monetary Amount	R	1	18	Line item charges denied or not covered.	S	NA		No	
Medical Record Number	127	Reference Identification	AN	1	30	A unique number assigned to patient by the provider to assist in retrieval of medical records.	S	NA	Used at discretion of submitter.	No	
Medicare Assignment Code	1359	Provider Accept Assignment Code	ID	1	1	An indication, used by Medicare or other government programs, that the provider accepted assignment.	R/S	Y	Always Required for professional billings. Situational for dental and institutional billings.	No	
Medicare Coverage Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code indicating the Medicare coverage exists.	S	Y		No	Home Hlth
Medicare Paid at 100% Amount	782	Monetary Amount	R	1	18	Amount of charges reported to be paid by Medicare at 100% of allowed amount.	S	NA		No	COB
Medicare Paid at 80% Amount	782	Monetary Amount	R	1	18	Amount of charges reported to be paid by Medicare at 80% of allowed amount.	S	NA		No	COB
Mental Status Code	1321	Condition Indicator	ID	2	2	Codes describing the patient's mental condition.	S	Y		No	Home Hlth
Non-Covered Charge Amount	782	Monetary Amount	R	1	18	Charges pertaining to the related revenue center code that the primary payer will not cover.	S	NA		No	COB
Nonpayable Professional Component Amount	782	Monetary Amount	R	1	18	Professional fees billed but not payable by payer.	S	NA		No	COB
Note Reference Code	363	Note Reference Code	ID	3	3	Code identifying the functional area or purpose for which the note applies.	S	Y		No	
Number of Visits	380	Quantity	R	1	15	The number of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating the number of visits, i.e., one.	S	NA		No	Home Hlth
Occurrence Code	1271	Industry Code	AN	1	30	Occurrence code as determined according to uniform bill instructions.	S	M		No	
Occurrence or Occurrence Span Code Associated Date	1251	Date Time Period	AN	1	35	Date associated with indicated code value.	S	NA		No	

Occurrence Span Code	1271	Industry Code	AN	1	30	A code that identifies an event that relates to payment of the claim. This event occurs over a span of days.	S	M		No	
Old Capital Amount	782	Monetary Amount	R	1	18	The amount for old capital for this claim.	S	NA		No	COB
Operating Physician First Name	1036	Name First	AN	1	25	First name of the physician performing the principle procedure.	S	NA		No	
Operating Physician Last Name	1035	Name Last or Organization Name	AN	1	35	Last name of the physician performing the principle procedure.	S	NA		No	
Operating Physician Middle Name	1037	Name Middle	AN	1	25	Middle name of the physician performing the principal procedure	S	NA		No	
Operating Physician Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the physician performing the principal procedure	S	NA		No	
Operating Physician Primary Identifier	67	Identification Code	AN	2	80	Primary identifier of the physician performing the principle procedure.	S	NA		No	
Operating Physician Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the physician performing the principal procedure	S	NA		No	
Originator Application Transaction Identifier	127	Reference Identification	AN	1	30	An identification number that identifies a transaction within the originator's applications system.	R	NA		No	
Other Diagnosis	1271	Industry Code	AN	1	30	Other diagnosis for this claim.	S	NA		Yes	
Other Insured Additional Identifier	127	Reference Identification	AN	1	30	Number providing additional identification of the other insured.	S	NA		No	COB
Other Insured Address Line	166	Address Information	AN	1	55	Address line of the additional insured individual's mailing address.	S	NA		No	COB
Other Insured Birth Date	1251	Date Time Period	AN	1	35	The birth date of the additional insured individual.	S	NA		No	COB
Other Insured City Name	19	City Name	AN	2	30	The city name of the additional insured individual.	S	NA		No	COB
Other Insured First Name	1036	Name First	AN	1	25	The first name of the additional insured individual.	S	NA		No	COB
Other Insured Gender Code	1068	Gender Code	ID	1	1	A code to specify the sex of the additional insured individual.	S	Y		No	COB
Other Insured Group Name	93	Name	AN	1	60	Name of the group or plan through which the insurance is provided to the other insured.	S	NA		No	COB
Other Insured Identifier	67	Identification Code	AN	2	80	An identification number, assigned by the third party payer, to identify the additional insured individual.	S	NA		No	COB
Other Insured Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the additional insured individual.	S	NA		No	COB
Other Insured Middle Name	1037	Name Middle	AN	1	25	The middle name of the additional insured individual.	S	NA		No	COB
Other Insured Name Suffix	1039	Name Suffix	AN	1	10	The suffix to the name of the additional insured individual.	S	NA		No	COB
Other Insured Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The Postal ZIP code of the additional insured individual's mailing address.	S	CL		No	COB
Other Insured State Code	156	State or Province Code	ID	2	2	The state code of the additional insured individual's mailing address.	S	CL		No	COB

Other Payer Address Line	166	Address Information	AN	1	55	Address line of the other payer's mailing address.	S	NA		No	COB
Other Payer Attending Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's attending provider identification.	S	NA		No	COB
Other Payer City Name	19	City Name	AN	2	30	The city name of the other payer's mailing address.	S	NA		No	COB
Other Payer Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The name of the other payer organization.	S	NA		No	COB
Other Payer Operating Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's operating provider identification.	S	NA		No	COB
Other Payer Other Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's other payer other provider identification.	S	NA		No	COB
Other Payer Patient Paid Amount	782	Monetary Amount	R	1	18	Amount reported by other payer as paid by the patient	S	NA		No	COB
Other Payer Patient Primary Identifier	67	Identification Code	AN	2	80	The non-destination (COB) payer's patient primary identification number.	S	NA		No	COB
Other Payer Patient Secondary Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's patient secondary identification number(s).	S	NA		No	COB
Other Payer Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP code of the other payer's mailing address.	S	CL		No	COB
Other Payer Primary Identifier	67	Identification Code	AN	2	80	An identification number for the other payer.	S	NA		No	COB
Other Payer Prior Authorization or Referral Number	127	Reference Identification	AN	1	30	The non-destination (COB) payer's claim line level prior authorization or referral number.	S	NA		No	COB
Other Payer Referring Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's referring provider identifier.	S	NA		No	COB
Other Payer Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the other payer organization	S	NA		No	COB
Other Payer Service Facility Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's service facility provider identifier.	S	NA		No	COB
Other Payer State Code	156	State or Province Code	ID	2	2	The state or province code of the other payer's mailing address.	S	CL		No	COB
Other Physician First Name	1036	Name First	AN	1	25	The First Name of the other licensed physician.	S	NA		No	
Other Physician Identifier	67	Identification Code	AN	2	80	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.	S	NA		No	
Other Physician Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of the other licensed physician.	S	NA		No	
Other Provider Identifier	67	Identification Code	AN	2	80	The number of the other licensed provider.	S	NA		No	
Other Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the other licensed provider.	S	NA		No	
Other Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the other licensed provider.	S	NA		No	
Other Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional name and/or number of the provider other than the attending provider as defined by the payer organization.	S	NA		No	

Paid From Part A Medicare Trust Fund Amount	782	Monetary Amount	R	1	18	Dollar amount paid for claim from the Part A Medicare Trust fund.	S	NA		No	COB
Paid From Part B Medicare Trust Fund Amount	782	Monetary Amount	R	1	18	Dollar amount paid for claim from the Part B Medicare Trust fund.	S	NA		No	COB
Patient Account Number	1028	Claim Submitter's Identifier	AN	1	38	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim.	R	NA		No	
Patient Address Line	166	Address Information	AN	1	55	Address line of the street mailing address of the patient.	R	NA		Yes	
Patient Amount Paid	782	Monetary Amount	R	1	18	The amount the provider has received from the patient (or insured) toward payment of this claim.	S	NA		Yes	
Patient Birth Date	1251	Date Time Period	AN	1	35	Date of birth of the patient.	R	NA		Yes	
Patient City Name	19	City Name	AN	2	30	The city name of the patient.	R	NA		Yes	
Patient Discharge Facility Type Code	1384	Patient Location Code	ID	1	1	The type of facility from which the patient was most recently discharged.	S	Y		No	Home Hlth
Patient First Name	1036	Name First	AN	1	25	The first name of the individual to whom the services were provided.	R	NA		Yes	
Patient Gender Code	1068	Gender Code	ID	1	1	A code indicating the sex of the patient.	R	Y		Yes	
Patient Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the individual to whom the services were provided.	R	NA		Yes	
Patient Middle Name	1037	Name Middle	AN	1	25	The middle name of the individual to whom the services were provided.	R	NA		Yes	
Patient Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the individual to whom the services were provided.	R	NA		Yes	
Patient Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the patient.	R	CL		Yes	
Patient Primary Identifier	67	Identification Code	AN	2	80	Identifier assigned by the payer to identify the patient	R	NA		No	
Patient Responsibility Amount	782	Monetary Amount	R	1	18	The amount determined to be the patient's responsibility for payment..	S	NA		No	
Patient Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier assigned to the patient by the payer.	S	NA		No	
Patient State Code	156	State or Province Code	ID	2	2	The State Postal Code of the patient.	R	CL		Yes	
Patient Status Code	1352	Patient Status Code	ID	1	2	A code indicating the patient's status at the date of admission, outpatient service, or start of care.	S	Y		No	
Patient Weight	81	Weight	R	1	10	Weight of the patient at time of treatment or transport.	S	NA		No	
Payer Additional Identifier	127	Reference Identification	AN	1	30	Additional identifier for the payer.	S	NA		No	
Payer Address Line	166	Address Information	AN	1	55	Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	NA		Yes	
Payer City Name	19	City Name	AN	2	30	The City Name of the Payer's claim mailing address for this particular payer ID and claim office.	S	NA		Yes	
Payer Identifier	67	Identification Code	AN	2	80	Number identifying the payer organization.	R	NA		Yes	

Payer Name	1035	Name Last or Organization Name	AN	1	35	Name identifying the payer organization.	R	NA		Yes	
Payer Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	CL		Yes	
Payer Responsibility Sequence Number Code	1138	Payer Responsibility Sequence Number Code	ID	1	1	Code identifying the insurance carrier's level of responsibility for a payment of a claim	R	Y		No	COB
Payer State Code	156	State or Province Code	ID	2	2	State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.	S	CL		Yes	
Pay-to Provider Additional Identifier	127	Reference Identification	AN	1	30	Additional identifier for pay-to provider.	S	NA		No	
Pay-to Provider Address Line	166	Address Information	AN	1	55	Address line of the provider to receive payment	S	NA		Yes	
Pay-to Provider City Name	19	City Name	AN	2	30	City name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization that will receive payment.	S	NA		Yes	
Pay-to Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last or organizational name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the provider to receive payment	S	CL		Yes	
Pay-to Provider State Code	156	State or Province Code	ID	2	2	State of the provider to receive payment.	S	CL		Yes	
Peer Review Authorization Number	127	Reference Identification	AN	1	30	Authorization number provided by a review organization after review completed	S	NA	Peer reviews.	No	
Physician Contact Date	373	Date	DT	8	8	Date of the home health agency's most recent contact with the physician.	S	NA		No	Home Hlth
Physician Order Date	373	Date	DT	8	8	Date the agency received the verbal orders from the physician for start of care.	S	NA		No	Home Hlth
Policy Compliance Code	1526	Policy Compliance Code	ID	1	2	The code that specifies policy compliance.	S	Y		No	
PPS-Capital DSH DRG Amount	782	Monetary Amount	R	1	18	PPS-capital disproportionate share amount for this claim as output by PPS-PRICER.	S	NA		No	COB
PPS-Capital Exception Amount	782	Monetary Amount	R	1	18	A per discharge payment exception paid to the hospital. It is a flat-rate add-on to the PPS payment.	S	NA		No	COB
PPS-Capital FSP DRG Amount	782	Monetary Amount	R	1	18	PPS-capital federal portion for this claim as output by PPS-PRICER.	S	NA		No	COB
PPS-Capital HSP DRG Amount	782	Monetary Amount	R	1	18	Hospital-Specific portion for PPS-capital for this claim as output by PPS-PRICER.	S	NA		No	COB
PPS-Capital IME amount	782	Monetary Amount	R	1	18	PPS-capital indirect medical expenses for this claim as output by PPS-PRICER.	S	NA		No	COB
PPS-Operating Federal Specific DRG Amount	782	Monetary Amount	R	1	18	Sum of federal operating portion of the DRG amount this claim as output by PPS-PRICER.	S	NA		No	COB
PPS-Operating Hospital Specific DRG Amount	782	Monetary Amount	R	1	18	Sum of hospital specific operating portion of DRG amount for this claim as output by PPS-PRICER.	S	NA		No	COB
Pregnancy Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A yes/no code indicating whether a patient is pregnant.	S	Y		No	
Prescription Number	127	Reference Identification	AN	1	30	The unique identification number assigned by the pharmacy or supplier to the prescription.	S	NA		Yes	

Pricing Methodology	1473	Pricing Methodology	ID	2	2	Pricing methodology at which the claim or line item has been priced or repriced.	S	Y		No	
Principal Procedure Code	1271	Industry Code	AN	1	30	Code identifying the principal procedure, product or service.	S	Y		Yes	
Prior Authorization Number	127	Reference Identification	AN	1	30	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization.	S	UB-92		No	
Procedure Code	234	Product/Service ID	AN	1	48	Code identifying the procedure, product or service.	R	CL		Yes	
Procedure Code	1271	Industry Code	AN	1	30	Code identifying the procedure, product or service.	S	CL		No	
Procedure Code Description	352	Description	AN	1	80	Description clarifying the Product/Service Procedure Code and related data elements.	S	NA		Yes	
Procedure Date	1251	Date Time Period	AN	1	35	Date when the health care procedure was performed.	S	NA		No	
Procedure Modifier	1339	Procedure Modifier	AN	2	2	This identifies special circumstances related to the performance of the service.	S	Y		No	
Product or Service ID Qualifier	235	Product/Service ID Qualifier	ID	2	2	Code identifying the type/source of the descriptive number used in Product/Service ID (234).	R/S	CL/Y		No	
Prognosis Code	923	Prognosis Code	ID	1	1	Code indicating physician's prognosis for the patient.	S	Y		No	Home Hlth
Property Casualty Claim Number	127	Reference Identification	AN	1	30	Identification number for property casualty claim associated with the services identified on the bill.	S	NA		No	
Provider Code	1221	Provider Code	ID	1	3	Code identifying the type of provider.	R/S	Y		No	
Provider or Supplier Signature Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office.	R	Y		No	
Provider Taxonomy Code	127	Reference Identification	AN	1	30	Code designating the provider type, classification, and specialization.	S	CL		No	
Quantity Qualifier	673	Quantity Qualifier	ID	2	2	Code specifying the type of quantity	S	Y		No	
Receiver Name	1035	Name Last or Organization Name	AN	1	35	Name of organization receiving the transaction.	R	NA		No	
Receiver Primary Identifier	67	Identification Code	AN	2	80	Primary identification number for the receiver of the transaction.	R	NA		No	

Reference Identification Qualifier	128	Reference Identification Qualifier	ID	2	3	Code qualifying the reference identification	R/S	Y		No	
Referring Provider First Name	1036	Name First	AN	1	25	The first name of provider who referred the patient to the provider of service on this claim.	S	NA		No	
Referring Provider Identifier	67	Identification Code	AN	2	80	The identification number for the referring physician.	S	NA		No	
Referring Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of Provider who referred the patient to the provider of service on this claim.	S	NA		No	
Referring Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider who is referring patient for care.	S	NA		No	
Referring Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider referring the patient for care.	S	NA		No	
Referring Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identification number for the provider referring the patient for service.	S	NA		No	
Reimbursement Rate	954	Percent	R	1	10	Rate used when payment is based upon a percentage of applicable charges.	S	NA		No	COB
Reject Reason Code	901	Reject Reason Code	ID	2	2	Code assigned by issuer to identify reason for rejection	S	Y		No	
Related Causes Code	1362	Related-Causes Code	ID	2	3	Code identifying an accompanying cause of an illness, injury, or an accident.	R/S	Y		No	
Release of Information Code	1363	Release of Information Code	ID	1	1	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.	R	Y		No	
Remark Code	127	Reference Identification	AN	1	30	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list.	S	Y		No	COB
Repriced Allowed Amount	782	Monetary Amount	R	1	18	The maximum amount determined by the repricer as being allowable under the provisions of the contract prior to the determination of the actual payment.	S	NA		No	
Repriced Approved Amount	782	Monetary Amount	R	1	18	The amount allowed by the repricer for the claim or service line net of adjustments.	S	NA		No	
Repriced Approved DRG Code	127	Reference Identification	AN	1	30	The Diagnosis Related Group approved by the repricer for payment for this claim	S	CL		No	
Repriced Approved HCPCS Code	234	Product/Service ID	AN	1	48	The HCPCS code that describes the services as approved by the repricer.	S	CL		No	
Repriced Approved Revenue Code	234	Product/Service ID	AN	1	48	UB92 revenue code approved by the repricer for payment on the claim.	S	CL		No	

Repriced Approved Service Unit Count	380	Quantity	R	1	15	Number of service units approved by pricing or repricing entity.	S	NA		No	
Repriced Claim Reference Number	127	Reference Identification	AN	1	30	Identification number, assigned by a repricing organization, to identify the claim.	S	NA		No	
Repriced Saving Amount	782	Monetary Amount	R	1	18	The amount of savings related to Third Party Organization claims.	S	NA		No	
Repricing Organization Identifier	127	Reference Identification	AN	1	30	Reference or identification number of the repricing organization.	S	NA		No	
Repricing Per Diem or Flat Rate Amount	118	Rate	R	1	9	Amount used to determine the flat rate or per diem price by the repricing organization.	S	NA		No	
Responsible Party Address Line	166	Address Information	AN	1	55	Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party City Name	19	City Name	AN	2	30	City name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party First Name	1036	Name First	AN	1	25	First name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party Middle Name	1037	Name Middle	AN	1	25	Middle name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	CL		Yes	
Responsible Party State Code	156	State or Province Code	ID	2	2	State or province of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations.	R	CL		Yes	
Responsible Party Suffix Name	1039	Name Suffix	AN	1	10	Suffix for name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Service Adjudication or Payment Date	1251	Date Time Period	AN	1	35	Date of payment or denial determination by previous payer when service line adjudication has been performed.	S	NA		No	
Service Authorization Exception Code	127	Reference Identification	AN	1	30	Code identifying the service authorization exception.	S	Y	Required when a service is provided without required prior authorization.	No	

Service Date	373	Date Time Period	AN	1	35	Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.	R/S	NA		Yes	
Service From Date	373	Date	DT	8	8	The date the service referenced in the claim or service line was initiated.	S	NA		No	Home Hlth
Service Line Paid Amount	782	Monetary Amount	R	1	18	Amount paid by the indicated payer for a service line	S	NA		No	
Service Line Rate	1371	Unit Rate	R	1	10	Payment rate that applies to the service line.	S	NA		No	
Service Line Revenue Code	234	Product/Service ID	AN	1	48	UB92 Revenue Code pertaining to the service line.	R	CL		No	
Service Tax Amount	782	Monetary Amount	R	1	18	The amount of service tax or surcharge applicable to the reported service	S	NA		No	
Service Unit Count	380	Quantity	R	1	15	The quantity of units, times, days, visits, services, or treatments for the service described by the HCPCS codes, revenue code or procedure code.	R	NA		Yes	
Ship, Delivery or Calendar Pattern Code"	678	Ship/Delivery or Calendar Pattern Code	ID	1	2	The time delivery pattern for the services.	S	Y		No	Home Hlth
Skilled Nursing Facility Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Code indicating whether or not a patient is receiving care in a 1861J1 (skilled nursing) facility	S	Y		No	Home Hlth
Special Program Indicator	1366	Special Program Code	ID	2	3	A code indicating the Special Program under which the services rendered to the patient were performed.	S	Y		No	
Statement From or To Date	1251	Date Time Period	AN	1	35	The date of the start or end of the period covered on the claim.	R	NA		No	
Submitter Contact Name	93	Name	AN	1	60	Name of the person at the submitter organization to whom inquiries about the transaction should be directed.	R	NA		No	
Submitter First Name	1036	Name First	AN	1	25	The first name of the person submitting the transaction or receiving the transaction, as identified by the preceding identification code.	S	NA		Yes	
Submitter Identifier	67	Identification Code	AN	2	80	Code or number identifying the entity submitting the claim.	R	M		No	
Submitter Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The last name or the organizational name of the entity submitting the transaction	R	NA		Yes	
Submitter Middle Name	1037	Name Middle	AN	1	25	The middle name of the person submitting the transaction	S	NA		Yes	
Subscriber Address Line	166	Address Information	AN	1	55	Address line of the current mailing address of the insured individual or subscriber to the coverage.	S	NA		Yes	COB
Subscriber Birth Date	1251	Date Time Period	AN	1	35	The date of birth of the subscriber to the indicated coverage or policy.	S	NA		Yes	COB
Subscriber City Name	19	City Name	AN	2	30	The City Name of the insured individual or subscriber to the coverage	S	NA		Yes	COB
Subscriber First Name	1036	Name First	AN	1	25	The first name of the insured individual or subscriber to the coverage		NA		Yes	COB
Subscriber Gender Code	1068	Gender Code	ID	1	1	Code indicating the sex of the subscriber to the indicated coverage or policy.		Y		Yes	COB
Subscriber Last Name	1035	Name Last or Organization Name	AN	1	35	The surname of the insured individual or subscriber to the coverage	R	NA		Yes	COB

Subscriber Middle Name	1037	Name Middle	AN	1	25	The middle name of the subscriber to the indicated coverage or policy.	S	NA		Yes	COB
Subscriber Name Suffix	1039	Name Suffix	AN	1	10	Suffix of the insured individual or subscriber to the coverage.	S	NA		Yes	COB
Subscriber Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the insured individual or subscriber to the coverage	S	CL		Yes	COB
Subscriber Primary Identifier	67	Identification Code	AN	2	80	Primary identification number of the subscriber to the coverage.	R/S	NA		Yes	COB
Subscriber State Code	156	State or Province Code	ID	2	2	The State Postal Code of the insured individual or subscriber to the coverage	S	CL		Yes	COB
Subscriber Supplemental Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the subscriber.	S	NA		No	COB
Surgery Date	373	Date	DT	8	8	Requested, anticipated, or actual date of surgery.	S	NA		No	Home Hlth
Surgical Procedure Code	1137	Medical Code Value	AN	1	15	Code describing the surgical procedure most relevant to the care being rendered.	S	CL		No	Home Hlth
Terms Discount Percentage	338	Terms Discount Percent	R	1	6	Discount percentage available to the payer for payment within a specific time period.	S	NA		No	
Total Claim Charge Amount	782	Monetary Amount	R	1	18	The sum of all charges included within this claim.	R	NA		No	
Total Medicare Paid Amount	782	Monetary Amount	R	1	18	Amount reported by the payer as paid by Medicare	S	NA		No	COB
Total Visits Projected This Certification Count	1470	Number	NO	1	9	Total covered visits to be rendered by each discipline during the period covered by the plan of treatment, including PRN visits.	S	NA		No	Home Hlth
Transaction Segment Count	96	Number of Included Segments	NO	1	10	A tally of all segments between the ST and the SE segments including the ST and SE segments.	R	NA		No	
Transaction Set Control Number	329	Transaction Set Control Number	AN	4	9	The unique identification number within a transaction set.	R	NA		No	
Transaction Set Creation Date	373	Date	DT	8	8	Identifies the date the submitter created the transaction	R	NA		No	
Transaction Set Creation Time	337	Time	TM	4	8	Time file is created for transmission.	R	NA		No	
Transaction Set Identifier Code	143	Reference Identification	AN	1	30	Code uniquely identifying a Transaction Set.	R	Y		No	
Transaction Set Purpose Code	353	Transaction Set Purpose Code	ID	2	2	Code identifying purpose of transaction set.	R	Y		No	
Transmission Type Code	127	Reference Identification	AN	1	30	Code identifying the type of transaction or transmission included in the transaction set.	R	Y		No	
Treatment Code	1271	Industry Code	AN	1	30	Code identifying treatment according to treatment code list instructions as determined according to uniform bill instructions	S	Y		No	Home Hlth
Unit or Basis for Measurement Code	355	Unit or Basis for Measurement Code	ID	2	2	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	S	Y		No	
Value Added Network Trace Number	127	Reference Identification	AN	1	30	Unique Identification number for a transaction assigned by a Value Added Network, Clearinghouse, or other transmission entity.	S	NA		No	

Value Code	1271	Industry Code	AN	1	30	The uniform billing value code communicating established billing information.	S	CL		No	
Value Code Associated Amount	782	Monetary Amount	R	1	18	Amount associated with indicated code value	S	NA		No	
Visits	673	Quantity Qualifier	ID	2	2	The unit for home health visitations. Example: One visit every three days for 21 days. This element qualifies that the data is communicating visits.	S	NA		No	Home Hlth
Visits Prior to Recertification Date Count	1470	Number	N0	1	9	Number of visits for care prior to the date of the recertification of services.	S	NA		No	Home Hlth

Client, Provider, or Claim Data	Implementation Guide		Implementation Guide		Implementation Guide	
	837-Institutional	Page #	837-Dental	Page #	837-Professional	Page #
CI	X	222, 223				
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CI-CR	X	185			X	235
CI	X	367, 368, 369, 370, 496, 497, 498, 499, 500, 501	X	216, 217, 218, 307, 308, 309, 310, 311	X	327, 328, 329, 330, 560, 561, 562, 563, 564, 565
CI	X	367, 368, 369, 370, 493, 496, 497, 498, 499, 500, 501	X	216, 217, 218, 219, 307, 308, 309, 310, 311	X	327, 328, 329, 330, 331, 560, 561, 562, 563, 564, 565
CI	X	367, 368, 369, 370, 496, 497, 498, 499, 500	X	216, 217, 218, 219, 307, 308, 309, 310, 311	X	326, 327, 328, 329, 330, 560, 561, 562, 563, 564, 565
CI	X	170				
CI	X	172				
CI	X	171				
CI-COB	X	372	X	222	X	334
CI	X	178, 180, 182, 184, 371, 372, 373, 374, 376, 378, 380, 382, 384, 386, 387, 460, 461	X	173, 174, 220, 221, 222, 223, 224, 225, 226, 287	X	219, 220, 221, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 484, 485, 486
CI	X	459				

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CI	X	175, 454	X	172	X	216
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CI	X	174, 453	X	171	X	215, 410
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CI	X	162	X	154	X	177
CI-COB	X	160, 390	X	153, 229	X	175, 345
CI	X	209				
PI	X	84	X	84	X	92
PI	X	79	X	80	X	88
PI	X	80	X	81	X	89
PI	X	88			X	97
PI	X	86	X	86	X	95
PI	X	78	X	78	X	86
PI	X	77	X	77	X	85
PI	X	81	X	82	X	90
PI	X	81	X	82	X	90

CP	X	493	X	304	X	557
CI	X	219			X	258, 261, 264, 428, 433
CI	X	221, 224				
CI	X	213			X	421, 424
CI	X	367, 495	X	216, 307	X	326, 560
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CI	X	393				
CI	X	393				
CI	X	375				
CI	X	399				
CI-COB	X	104, 363	X	101, 211	X	112, 321
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CI	X	398				
CI	X	395				
CI	X	394				
CI	X	207	X	186, 288	X	247
CI	X	59	X	56	X	65
CP	X	192	X	180	X	230
CI	X	394				
CI	X	395				

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CI	X	177			X	218, 467
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CI	X	395				
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CI	X	393				
CI-COB	X	125	X	130	X	150
CI-COB	X	122			X	147
CI-COB	X	122	X	127	X	147

CI-COB	X	122	X	127	X	147
CI-COB	X	122	X	127	X	147
CI-COB	X	184	X	174	X	219
CI-COB	X	123	X	128	X	148
CI	X	74	X	74	X	82
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CI	X	165, 167, 169, 415, 456, 458, 502	X	157, 158, 160-162, 164, 246, 273, 275, 277, 279, 312	X	180, 182, 184, 186, 188, 190, 192, 194, 196, 197, 199-201, 203, 205, 206, 208, 210, 213, 366, 435, 437, 439, 440, 442, 444, 445, 447, 449, 451, 452, 454, 456, 458, 460, 566
CI	X	164	X	155	X	179
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CI	X	230				
CI	X	166				
CI-HH	X	314			X	276
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CI-HH	X	318			X	280, 493
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CI	X	179				
CI	X	313			X	275, 500
CI	X	163				
CI	X	159				
CI	X	461				
CI	X	159	X	151, 268	X	173
CI	X	204			X	245, 487
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CI-HH	X	317			X	279, 492
CI-HH	X	222, 225				
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CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
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CP	X	57	X	54	X	63
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CI-COB	X	103, 363	X	100, 210	X	111, 320
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CI-HH	X	215				
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CI-COB	X	393				
CP	X	448	X	268	X	402
CP	X	449				
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CI-COB	X	380				
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CI-COB	X	395, 399				
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CI-COB	X	409	X	239	X	358
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CI-COB	X	389	X	228	X	343
CI-COB	X	406	X	236	X	355
CI-COB	X	401	X	232	X	351
CI-COB	X	389	X	228	X	343
CI-COB	X	363			X	320
CI-COB	X	403	X	233	X	352
CI-COB	X	401	X	232	X	351
CI-COB	X	402	X	232	X	351
CI-COB	X	402	X	232	X	352
CI-COB	X	407	X	237	X	356
CI-COB	X	407	X	237	X	356

CI-COB	X	412				
CI-COB	X	427				
CI-COB	X	413				
CI-COB	X	411	X	241, 298	X	360
CI-COB	X	431				
CI-COB	X	435				
CI-COB	X	371	X	226	X	339
CI-COB	X	421	X	254	X	375
CI-COB	X	423			X	377
CI-COB	X	414				
CI-COB	X	411	X	241, 302	X	361, 555
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CI-COB	X	439	X	260	X	381
CI-COB	X	417	X	248	X	369
CI-COB	X	443				
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CI-COB	X	385				
CI	X	158	X	150	X	171
CD	X	148	X	140	X	161
CD	X	183	X	173	X	220
CD	X	152	X	144	X	165
CD	X	149	X	141	X	162
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CD	X	152	X	144	X	165
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CD	X	146	X	137	X	158
CD	X	146	X	137	X	158
CD	X	150	X	142	X	163
CD	X	147	X	138	X	159
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CD	X	154	X	146	X	167
CD	X	150	X	142	X	162
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CI	X	94	X	91	X	103
CI	X	95	X	92	X	104
CI	X	93	X	89	X	101
CI	X	92	X	88	X	100
CI	X	95	X	93	X	105
CI	X	95	X	93	X	104
CI	X	197				
CI-HH	X	215				
CI-HH	X	214				
CI-CR	X	312			X	274, 499
CI-COB	X	394				
CI-COB	X	396				
CI-COB	X	394				
CI-COB	X	394				
CI-COB	X	395				
CI-COB	X	395				
CI-COB	X	395				
CD	X	107, 144			X	116, 156
CI	X	451			X	409

CI-CR	X	309			X	272, 496
CI	X	243				
CI	X	199				
CI	X	447, 492	X	267, 302	X	401, 498, 556
CI	X	245-254				
CI	X	492	X	303	X	557
CI	X	245-255				
CI	X	447, 448, 492	X	267, 303	X	401, 402, 556
CI	X	214, 311, 446, 491	X	266, 302	X	401, 498, 555
CI-HH	X	211				
CI	X	120, 156	X	116, 148	X	129, 169
PI	X	71, 324, 331, 338, 345, 352, 465, 472, 479, 486	X	71, 190, 198, 292	X	79, 285, 293, 504, 544
CI	X	160	X	152	X	174
PI	X	72, 325, 332, 339, 346, 353, 466, 473, 480, 487	X	72, 191, 199, 293	X	80, 286, 294, 505, 545
CI	X	306	X	281	X	462
CI	X	68	X	67	X	75
CI	X	68	X	67	X	75

CP	X	60, 72, 83, 85, 97, 117, 120, 124, 132, 153, 155, 185, 186, 187, 189, 191, 193, 195, 197, 198, 200, 202, 325, 326, 332, 333, 339, 340, 346, 347, 353, 357, 408, 416, 418, 422, 426, 430, 434, 438, 442, 465, 467, 473, 474, 480, 481, 487, 488	X	57, 72, 84, 85, 95, 113, 115, 124, 130, 145, 147, 175, 177, 180, 182, 184, 190, 193, 199, 201, 207, 238, 247, 249, 252, 255, 259, 263, 283, 284, 285, 292, 295, 300	X	66, 80, 92, 94, 106, 126, 128, 137, 150, 166, 168, 222, 224, 226, 228, 230, 232, 233, 235, 236, 239-242, 286, 288, 294, 296, 301, 310, 316, 357, 368, 370, 373, 376, 380, 384, 388, 392, 396, 468-470, 472, 474, 475, 477-480, 483, 504, 507, 512, 521, 527, 536, 545, 547, 552
CI	X	343, 484	X	188	X	283, 542
CI	X	344	X	189	X	284, 543
CI	X	343, 484	X	188	X	283, 379, 542
CI	X	344, 484	X	189	X	284, 543
CI	X	344, 484	X	189	X	284, 543
CI	X	348, 489	X	194	X	289, 548
CI-COB	X	397			X	347
CI-CR	X	312			X	274, 499
CI	X	161, 162	X	153, 154	X	176, 177
CI	X	161, 391	X	153, 230	X	175, 345
CI-COB	X	393, 396, 398, 399			X	348, 349
CI-CR	X	309			X	272, 496
CI-CR	X	310				
CI-CR	X	310				
CI-CR	X	311				
CI-CR	X	311				

CI-CR	X	312			X	499
CI-CR	X	186			X	233
CI-CR	X	310			X	273, 497
CI-CR	X	310			X	273, 497
CI-CR	X	310			X	273, 497
CI	X	136			X	143
CI	X	137			X	144
CI	X	135			X	140
CI	X	135			X	140
CI	X	135			X	141
CI	X	137			X	145
CI	X	137			X	144
CI	X	135			X	141
CP	X	502				
CI	X	196	X	178	X	223

CI	X	457	X	165, 274	X	436
CI-HH	X	211				
CP	X	491	X	302	X	555
CI	X	449				
CI	X	446, 492				
CI	X	460				
CI	X	449			X	403
CI-HH	X	318			X	280, 493
CI-HH	X	212				
CI	X	163	X	155	X	178
CI	X	168				
PI	X	65	X	64	X	72
PI	X	62	X	60	X	68
PI	X	63	X	61	X	69
PI	X	62	X	60	X	68
PI	X	62	X	60	X	68
CI-COB	X	112	X	108	X	121
CI-COB	X	116	X	112	X	125
CI-COB	X	113	X	109	X	122
CI-COB	X	109	X	104	X	118
CI-COB	X	116	X	112	X	125
CI-COB	X	109	X	104	X	118

CI-COB	X	109	X	104	X	118
CI-COB	X	110	X	105	X	118
CI-COB	X	114	X	110	X	123
CI-COB	X	110	X	106	X	119
CI-COB	X	114	X	110	X	123
CI-COB	X	118	X	114	X	127
CI-HH	X	213				
CI-HH	X	214				
CI	X	177			X	218
CP	X	159	X	151	X	172
CI-COB	X	377				
CI-HH	X	315				
CP	X	503	X	313	X	572
CP	X	56, 503	X	53, 313	X	62, 572
CP	X	58	X	55	X	64
CP	X	58	X	56	X	65
CP	X	56	X	53	X	62
CP	X	58	X	55	X	64
CP	X	60	X	57	X	66
CI-HH	X	300-305				
CI	X	107, 144, 307, 311, 448			X	115, 156, 249, 250, 254, 403, 413, 414, 418, 422, 498
CP	X	188	X	184		

CI	X	281-288				
CI	X	281-289				
CI-HH	X	317			X	279, 492
CI-HH	X	315				

837-Dental Data Elements						FIELD LENGTH		Required or Situati'	Guide	Commentary	Currently captured by DMH	Service
Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition						
Accident Date	1251	Date Time Period	AN	1	35	Date of the accident related to charges or to the patient's current condition, diagnosis, or treatment referenced in the transaction.		S	NA		No	
Additional Submitter Name	93	Name	AN	1	60	Additional name information for the receiver or submitter of the transaction.		S	NA	This is only required if the name is over 35 characters.	No	
Adjudication or Payment Date	1251	Date Time Period	AN	1	35	Date of payment or denial determination by previous payer.		S	NA		No	
Adjustment Amount	782	Monetary Amount	R	1	18	Adjustment amount for the associated reason code.		R	NA		No	
Adjustment Quantity	380	Quantity	R	1	15	Numeric quantity associated with the related reason code for coordination of benefits.		R	NA		No	
Adjustment Reason Code	1034	Claim Adjustment Reason Code	ID	1	5	Code that indicates the reason for the adjustment.		R	CL		No	
Allowed Amount	782	Monetary Amount	R	1	18	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment.		R	NA		No	COB
Amount Qualifier Code	522	Amount Qualifier Code	ID	1	3	Code to qualify amount.		S	Y		No	
Anesthesia Unit Count	380	Quantity	R	1	15	Number of anesthesia units provided to patient		S	NA		No	
Approved Amount	782	Monetary Amount	R	1	18	Amount approved.		S	NA		No	COB
Assigned Number	554	Assigned Number	N0	1	6	Number assigned for differentiation within a transaction set.		R	NA		No	
Attachment Control Number	67	Identification Code	AN	2	80	Identification number of attachment related to the claim.		S	M	Needed if there are paper attachments to a claim.	No	
Attachment Report Type Code	755	Report Type Code	ID	2	2	Code to specify the type of attachment that is related to the claim.		S	Y	Needed if there are paper attachments to a claim.	No	
Attachment Transmission Code	756	Report Transmission Code	ID	1	2	Code defining timing, transmission method or format by which an attachment report is to be sent or has been sent.		S	Y	Needed if there are paper attachments to a claim.	No	

Auto Accident State or Province Code	156	State or Province Code	ID	2	2	State or Province where auto accident occurred.	S	CL		No	
Benefits Assignment Certification Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.	R	Y		No	COB
Billing Provider Additional Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the billing provider	S	NA		No	
Billing Provider Additional Name	93	Name	AN	1	60	Additional names or characters for the billing provider or billing entity for the transaction.	S	NA	This is only required if the name is over 35 characters.	No	
Billing Provider Address Line	166	Address Information	AN	1	55	Address line of the billing provider or billing entity address.	R	NA		Yes	
Billing Provider City Name	19	City Name	AN	2	30	City of the billing provider or billing entity	R	NA		Yes	
Billing Provider Credit Card Identifier	127	Reference Identification	AN	1	30	Identification number for credit card processing for the billing provider or billing entity	S	NA		No	
Billing Provider First Name	1036	Name First	AN	1	25	First name of the billing provider or billing entity	S	NA		Yes	
Billing Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.	R	NA		Yes	
Billing Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the provider billing or billing entity for services.	R	NA		Yes	
Billing Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the billing provider or billing entity	R	NA		Yes	
Billing Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix, including generation, for the name of the provider or billing entity submitting the claim.	R	NA		Yes	
Billing Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal zone code or ZIP code for the provider or billing entity billing for services.	R	CL		Yes	
Billing Provider State or Province Code	156	State or Province Code	ID	2	2	State or province for provider or billing entity billing for services.	R	CL		Yes	
Bundled or Unbundled Line Number	554	Assigned Number	NO	1	6	Identification of line item bundled or unbundled by payer in coordination of benefits.	S			No	
Claim Adjustment Group Code	1033	Claim Adjustment Group Code	ID	1	2	Code identifying the general category of payment adjustment.	S	Y		No	
Claim Filing Indicator Code	1032	Claim Filing Indicator Code	ID	1	2	Code identifying type of claim or expected adjudication process.	S	Y		No	COB
Claim Note Text	352	Description	AN	1	80	Narrative text providing additional information related to the claim.	S	NA	This is for when you need to note additional information.	No	
Claim or Encounter Identifier	640	Transaction Type Code	ID	2	2	Code indicating whether the transaction is a claim or reporting encounter information.	R	Y		No	
Claim Original Reference Number	127	Reference Identification	AN	1	30	Number assigned by a processor to identify a claim.	S	NA		No	
Claim Submission Reason Code	1325	Claim Frequency Type Code	ID	1	1	Code identifying reason for claim submission	R	M		No	
Claim Submission Reason Code	1383	Claim Submission Reason Code	ID	2	2	Code identifying reason for claim submission	S	Y		No	
Code List Qualifier Code	1270	Code List Qualifier Code	ID	1	3	Code identifying a specific industry code list.	R	Y		No	

Communication Number	364	Communication Number	AN	1	80	Complete communications number including country or area code when applicable	R	NA	This is the biller's phone/fax/e-mail/edi number.	Yes	
Communication Number Qualifier	365	Communication Number Qualifier	ID	2	2	Code identifying the type of communication number	R	Y		No	
Contact Function Code	366	Contact Function Code	ID	2	2	Code identifying the major duty or responsibility of the person or group named.	R	Y		No	
Coordination of Benefits Code	1143	Coordination of Benefits Code	ID	1	1	Code identifying whether there is a coordination of benefits	R	Y		Yes	Dental
Country Code	26	Country Code	ID	2	3	Code indicating the geographic location.	S	CL	This is required when the biller's address is outside the United States.	No	
Covered Amount	782	Monetary Amount	R	1	18	Amount determined to be covered for the claim for coordination of benefits.	S	NA		Yes	COB
Credit or Debit Card Authorization Number	127	Reference Identification	AN	1	30	Credit/Debit card authorization number used to authorize use of card for payment for billed charges.	S	NA		No	
Credit or Debit Card Holder Additional Name	93	Name	AN	1	60	Additional name information for the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA	This is only required if the name is over 35 characters.	No	
Credit or Debit Card Holder Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Holder Middle Name	1037	Name Middle	AN	1	25	Middle name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Holder Name Suffix	1039	Name Suffix	AN	1	10	Name suffix of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Maximum Amount	782	Monetary Amount	R	1	18	Dollar limit for a credit or debit card	S	NA		No	COB
Credit or Debit Card Number	67	Identification Code	AN	2	80	Credit/Debit card number that may be used to pay for billed charges.	S	NA		No	COB
Currency Code	100	Currency Code	ID	3	3	Code for country in whose currency the charges are specified.	S	CL	Only needed for foreign currency.	No	
Date Claim Paid	1251	Date Time Period	AN	1	35	Code indicating the date the claim was paid.	S	NA		No	
Date Time Period Format Qualifier	1250	Date Time Period Format Qualifier	ID	2	3	Code indicating the date format, time format, or date and time format	S	Y	Required when the patient is the same as the subscriber.	No	

Date Time Qualifier	374	Date/Time Qualifier	ID	3	3	Code specifying the type of date or time or both date and time.	S	Y		No	
Delay Reason Code	1514	Delay Reason Code	ID	1	2	Code indicating the reason why a request was delayed.	S	Y		No	
Discharge or End Of Care Date	1251	Date Time Period	AN	1	35	Date that the patient was discharged from inpatient care or care/treatment ended.	S	NA		No	
Entity Identifier Code	98	Entity Identifier Code	ID	2	3	Code identifying an organizational entity, a physical location, property or an individual	R	Y		No	
Entity Type Qualifier	1065	Entity Type Qualifier	ID	1	1	Code qualifying the type of entity	R	Y		No	
Entity Type Qualifier	1036	Entity Type Qualifier	ID	1	1	Code qualifying the type of entity	S	NA		No	
Facility Type Code	1331	Facility Code Value	AN	1	2	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.	R	Y		No	
Hierarchical Child Code	736	Hierarchical Child Code	ID	1	1	Code indicating if there are hierarchical child data segments subordinate to the level being described.	R	Y		No	
Hierarchical ID Number	628	Hierarchical ID Number	AN	1	12	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.	R	NA		No	
Hierarchical Level Code	735	Hierarchical Level Code	ID	1	2	Code defining the characteristic of a level in a hierarchical structure.	R	Y		No	
Hierarchical Parent ID Number	734	Hierarchical Parent ID Number	AN	1	12	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.	R	NA		No	
Hierarchical Structure Code	1005	Hierarchical Structure Code	ID	4	4	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	R	Y		No	
Identification Code Qualifier	66	Identification Code Qualifier	ID	1	2	Code designating the system/method of code structure used for Identification Code (67)	R	Y		No	
Individual Relationship Code	1069	Individual Relationship Code	ID	2	2	Code indicating the relationship between two individuals or entities			Differs from the information in CTRAC	No	

Insured Group Name	93	Name	AN	1	60	Name of the group or plan through which the insurance is provided to the insured.	S	NA		Yes	COB
Insured Group or Policy Number	127	Identification Code	AN	2	80	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	S	NA		No	COB
Laboratory or Facility Name	1035	Name Last or Organization Name	AN	1	35	Name of laboratory or other facility performing Laboratory testing on the claim where the health care service was performed/rendered.	R	NA		Yes	
Laboratory or Facility Name Additional Text	93	Name	AN	1	60	Additional name information identifying the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	S	NA	This is only required if the name is over 35 characters.	No	
Laboratory or Facility Primary Identifier	67	Identification Code	AN	2	80	Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.	R	NA		No	
Laboratory or Facility Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	S	NA		No	
Line Item Charge Amount	782	Monetary Amount	R	1	18	Charges related to this service.	R	NA		No	
Line Item Control Number	127	Reference Identification	AN	1	30	Identifier assigned by the submitter/provider to this line item.	S	NA		No	
Location Qualifier	98	Entity Identifier Code	ID	2	3	Code identifying type of location.	S	Y		No	Dental
Loop Identifier Code	1065	Information Receiver Last or Organization Name	AN	1	1	The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE.	S	Y		No	Dental
Medicare Assignment Code	1359	Provider Accept Assignment Code	ID	1	1	An indication, used by Medicare or other government programs, that the provider accepted assignment.	R/S	Y	Always Required for professional billings. Situational for dental and institutional billings.	No	
Note Reference Code	363	Note Reference Code	ID	3	3	Code identifying the functional area or purpose for which the note applies.	S	Y		No	
Oral Cavity Designation Code	1361	Oral Cavity Designation Code	ID	1	3	Code identifying an oral cavity involved in the service.	R	Y		Yes	Dental
Originator Application Transaction Identifier	127	Reference Identification	AN	1	30	An identification number that identifies a transaction within the originator's applications system.	R	NA		No	
Orthodontic Banding Date	1251	Date Time Period	AN	1	35	Date that Orthodontic bands were applied.	S	NA		No	Dental
Orthodontic Treatment Months Count	380	Quantity	R	1	15	Estimated Number of Treatment Months for Orthodontic Treatment	S	NA		No	Dental
Orthodontic Treatment Months Remaining Count	380	Quantity	R	1	15	Number of Treatment Months Remaining for Orthodontic Treatment	S	NA		No	Dental
Other Insured Additional Identifier	127	Reference Identification	AN	1	30	Number providing additional identification of the other insured.	S	NA		No	COB
Other Insured Additional Name	93	Name	AN	1	60	Additional name information for the other insured.	S	NA	This is only required if the name is over 35 characters.	No	COB
Other Insured Address Line	166	Address Information	AN	1	55	Address line of the additional insured individual's mailing address.	S	NA		No	COB
Other Insured Birth Date	1251	Date Time Period	AN	1	35	The birth date of the additional insured individual.	S	NA		No	COB

Other Insured City Name	19	City Name	AN	2	30	The city name of the additional insured individual.	S	NA		No	COB
Other Insured First Name	1036	Name First	AN	1	25	The first name of the additional insured individual.	S	NA		No	COB
Other Insured Gender Code	1068	Gender Code	ID	1	1	A code to specify the sex of the additional insured individual.	S	Y		No	COB
Other Insured Identifier	67	Identification Code	AN	2	80	An identification number, assigned by the third party payer, to identify the additional insured individual.	S	NA		No	COB
Other Insured Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the additional insured individual.	S	NA		No	COB
Other Insured Middle Name	1037	Name Middle	AN	1	25	The middle name of the additional insured individual.	S	NA		No	COB
Other Insured Name Suffix	1039	Name Suffix	AN	1	10	The suffix to the name of the additional insured individual.	S	NA		No	COB
Other Insured Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The Postal ZIP code of the additional insured individual's mailing address.	S	CL		No	COB
Other Insured State Code	156	State or Province Code	ID	2	2	The state code of the additional insured individual's mailing address.	S	CL		No	COB
Other Payer Additional Name Text	93	Name	AN	1	60	Additional name information for the other payer organization.	S	NA	This is only required if the name is over 35 characters.	No	COB
Other Payer Claim Adjustment Indicator	127	Reference Identification	AN	1	30	Indicates the other payer has made a previous claim adjustment to this claim.	S	Y		No	COB
Other Payer Contact Name	93	Name	AN	1	60	Name of other payer contact.	S	NA		No	COB
Other Payer Discount Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be subject to discount provisions.	S	NA		No	COB
Other Payer Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The name of the other payer organization.	S	NA		No	COB
Other Payer Patient Last Name	1035	Name Last or Organization Name	AN	1	35	The non-destination (COB) payer's patient's last name.	S	NA		No	COB
Other Payer Patient Paid Amount	782	Monetary Amount	R	1	18	Amount reported by other payer as paid by the patient	S	NA		No	COB
Other Payer Patient Primary Identifier	67	Identification Code	AN	2	80	The non-destination (COB) payer's patient primary identification number.	S	NA		No	COB
Other Payer Patient Primary Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's patient primary identification number.	S	NA		No	COB
Other Payer Primary Identifier	67	Identification Code	AN	2	80	An identification number for the other payer.	S	NA		No	COB
Other Payer Prior Authorization or Referral Number	127	Reference Identification	AN	1	30	The non-destination (COB) payer's claim line level prior authorization or referral number.	S	NA		No	COB
Other Payer Referral Number	67	Identification Code	AN	2	80	The non-destination (COB) payer's claim line level referral number.	S	NA		No	COB
Other Payer Referring Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's referring provider identifier.	S	NA		No	COB
Other Payer Rendering Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's rendering provider identifier.	S	NA		No	COB
Other Payer Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the other payer organization	S	NA		No	COB

Paid Service Unit Count	380	Quantity	R	1	15	Units of service paid by the payer for coordination of benefits.	S	NA		No	
Patient Account Number	1028	Claim Submitter's Identifier	AN	1	38	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim.	R	NA		No	
Patient Additional Name	93	Name	AN	1	60	Additional name information for the patient.	S	NA	This is only required if the name is over 35 characters.	No	
Patient Address Line	166	Address Information	AN	1	55	Address line of the street mailing address of the patient.	R	NA		Yes	
Patient Amount Paid	782	Monetary Amount	R	1	18	The amount the provider has received from the patient (or insured) toward payment of this claim.	S	NA		Yes	
Patient Birth Date	1251	Date Time Period	AN	1	35	Date of birth of the patient.	R	NA		Yes	
Patient City Name	19	City Name	AN	2	30	The city name of the patient.	R	NA		Yes	
Patient First Name	1036	Name First	AN	1	25	The first name of the individual to whom the services were provided.	R	NA		Yes	
Patient Gender Code	1068	Gender Code	ID	1	1	A code indicating the sex of the patient.	R	Y		Yes	
Patient Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the individual to whom the services were provided.	R	NA		Yes	
Patient Middle Name	1037	Name Middle	AN	1	25	The middle name of the individual to whom the services were provided.	R	NA		Yes	
Patient Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the individual to whom the services were provided.	R	NA		Yes	
Patient Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the patient.	R	CL		Yes	
Patient Primary Identifier	67	Identification Code	AN	2	80	Identifier assigned by the payer to identify the patient	R	NA		No	
Patient Responsibility Amount	782	Monetary Amount	R	1	18	The amount determined to be the patient's responsibility for payment..	S	NA		No	
Patient Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier assigned to the patient by the payer.	S	NA		No	
Patient State Code	156	State or Province Code	ID	2	2	The State Postal Code of the patient.	R	CL		Yes	
Payer Additional Identifier	127	Reference Identification	AN	1	30	Additional identifier for the payer.	S	NA		No	
Payer Additional Name	93	Name	AN	1	60	Additional name information for the payer.	S	NA	This is only required if the name is over 35 characters.	No	
Payer Address Line	166	Address Information	AN	1	55	Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	NA		Yes	
Payer City Name	19	City Name	AN	2	30	The City Name of the Payer's claim mailing address for this particular payer ID and claim office.	S	NA		Yes	
Payer Identifier	67	Identification Code	AN	2	80	Number identifying the payer organization.	R	NA		Yes	
Payer Name	1035	Name Last or Organization Name	AN	1	35	Name identifying the payer organization.	R	NA		Yes	
Payer Paid Amount	782	Monetary Amount	R	1	18	The amount paid by the payer on this claim.	S	NA		Yes	

Payer Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	CL		Yes	
Payer Postal Zone or ZIP Code	26	Postal Code	ID	3	15	The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	CL		Yes	
Payer Responsibility Sequence Number Code	1138	Payer Responsibility Sequence Number Code	ID	1	1	Code identifying the insurance carrier's level of responsibility for a payment of a claim	R	Y		No	COB
Payer State Code	156	State or Province Code	ID	2	2	State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.	S	CL		Yes	
Pay-to Provider Additional Name	93	Name	AN	1	60	Additional name information for the provider to receive payment.	S	NA	This is only required if the name is over 35 characters.	No	
Pay-to Provider Address Line	166	Address Information	AN	1	55	Address line of the provider to receive payment	S	NA		Yes	
Pay-to Provider City Name	19	City Name	AN	2	30	City name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider First Name	1036	Name First	AN	1	25	First name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization that will receive payment.	S	NA		Yes	
Pay-to Provider Identifier	127	Reference Identification	AN	1	30	Identification number for the provider or organization that will receive payment.	S	NA		No	
Pay-to Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last or organizational name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the pay-to provider.	S	NA		Yes	
Pay-to Provider Name Suffix	1039	Name Suffix	AN	1	10	The suffix, including generation, of the provider that will receive payment.	S	NA		Yes	
Pay-to Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the provider to receive payment	S	CL		Yes	
Pay-to Provider State Code	156	State or Province Code	ID	2	2	State of the provider to receive payment.	S	CL		Yes	
Policy Name	93	Name	AN	1	60	The name of the policy providing coverage.	S	NA		Yes	COB
Predetermination of Benefits Identifier	127	Reference Identification	AN	1	30	Identifier or authorization number assigned to Predetermination of Benefits.	S	NA		No	Dental
Prior Placement Date	1251	Date Time Period	AN	1	35	The date of Prior Placement of the Prosthesis, Crown or Inlay, if any reason for service is replacement.	S	NA		Yes	Dental
Procedure Code	234	Product/Service ID	AN	1	48	Code identifying the procedure, product or service.	R	CL		Yes	
Procedure Code Description	352	Description	AN	1	80	Description clarifying the Product/Service Procedure Code and related data elements.	S	NA		Yes	
Procedure Count	380	Quantity	R	1	15	Number of Procedures	R	NA		Yes	Dental
Procedure Modifier	1339	Procedure Modifier	AN	2	2	This identifies special circumstances related to the performance of the service.	S	Y		No	

Product or Service ID Qualifier	235	Product/Service ID Qualifier	ID	2	2	Code identifying the type/source of the descriptive number used in Product/Service ID (234).	R/ S	CL/ Y		No	
Property Casualty Claim Number	127	Reference Identification	AN	1	30	Identification number for property casualty claim associated with the services identified on the bill.	S	NA		No	
Prosthesis, Crown, or Inlay Code"	1358	"Prosthesis, Crown or Inlay Code"	ID	1	1	Code Specifying the Placement Status for the Dental Work	S	Y		No	Dental
Provider Code	1221	Provider Code	ID	1	3	Code identifying the type of provider.	R/ S	Y		No	
Provider or Supplier Signature Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office.	R	Y		No	
Provider Taxonomy Code	127	Reference Identification	AN	1	30	Code designating the provider type, classification, and specialization.	S	CL		No	
Quantity Qualifier	673	Quantity Qualifier	ID	2	2	Code specifying the type of quantity	S	Y		No	
Question Response	1073	Yes/No Condition or Response Code	ID	1	1	A yes/no question response.	S	Y		No	
Receiver Additional Name	93	Name	AN	1	60	Additional name information for the receiver.	S	NA	This is only required if the name is over 35 characters.	No	
Receiver Name	1035	Name Last or Organization Name	AN	1	35	Name of organization receiving the transaction.	R	NA		No	
Receiver Primary Identifier	67	Identification Code	AN	2	80	Primary identification number for the receiver of the transaction.	R	NA		No	
Reference Identification Qualifier	128	Reference Identification Qualifier	ID	2	3	Code qualifying the reference identification	R/ S	Y		No	
Referral Date	1251	Date Time Period	AN	1	35	Date of referral.	S	NA		No	
Referral Number	127	Reference Identification	AN	1	30	Referral authorization number.	S	NA		No	
Referring Provider First Name	1036	Name First	AN	1	25	The first name of provider who referred the patient to the provider of service on this claim.	S	NA		No	
Referring Provider Identifier	67	Identification Code	AN	2	80	The identification number for the referring physician.	S	NA		No	
Referring Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of Provider who referred the patient to the provider of service on this claim.	S	NA		No	
Referring Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider who is referring patient for care.	S	NA		No	

Referring Provider Name Additional Text	93	Name	AN	1	60	Additional name information identifying the referring provider.	S	NA	This is only required if the name is over 35 characters.	No	
Referring Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider referring the patient for care.	S	NA		No	
Referring Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identification number for the provider referring the patient for service.	S	NA		No	
Related Causes Code	1362	Related-Causes Code	ID	2	3	Code identifying an accompanying cause of an illness, injury, or an accident.	R/S	Y		No	
Related Hospitalization Admission Date	1251	Date Time Period	AN	1	35	The date the patient was admitted for inpatient care related to current service.	S	NA		No	
Release of Information Code	1363	Release of Information Code	ID	1	1	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.	R	Y		No	
Rendering Provider First Name	1036	Name First	AN	1	25	The first name of the provider who performed the service.	S	NA		Yes	
Rendering Provider Identifier	67	Identification Code	AN	2	80	The identifier assigned by the Payor to the provider who performed the service.	S	NA		Yes	
Rendering Provider Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The last name or organization of the provider who performed the service	S	NA		Yes	
Rendering Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider who has provided the services to the patient.	S	NA		Yes	
Rendering Provider Name Additional Text	93	Name	AN	1	60	Additional name information identifying the rendering provider.	S	NA	This is only required if the name is over 35 characters.	No	
Rendering Provider Name Suffix	1039	Name Suffix	AN	1	10	Name suffix of the provider who has provided the services to the patient.	S	NA		Yes	
Rendering Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider providing care to the patient.	S	NA		Yes	
Replacement Date	1251	Date Time Period	AN	1	35	Replacement Date for appliance or prosthesis	S	NA		No	Dental
Service Authorization Exception Code	127	Reference Identification	AN	1	30	Code identifying the service authorization exception.	S	Y	Required when a service is provided without required prior authorization.	No	
Service Date	373	Date Time Period	AN	1	35	Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.	R/S	NA		Yes	
Service Line Paid Amount	782	Monetary Amount	R	1	18	Amount paid by the indicated payer for a service line	S	NA		No	
Special Program Indicator	1366	Special Program Code	ID	2	3	A code indicating the Special Program under which the services rendered to the patient were performed.	S	Y		No	
Student Status Code	1220	Student Status Code	ID	1	1	Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured	S	Y		No	Dental
Submitter Contact Name	93	Name	AN	1	60	Name of the person at the submitter organization to whom inquiries about the transaction should be directed.	R	NA		No	
Submitter First Name	1036	Name First	AN	1	25	The first name of the person submitting the transaction or receiving the transaction, as identified by the preceding identification code.	S	NA		Yes	

Submitter Identifier	67	Identification Code	AN	2	80	Code or number identifying the entity submitting the claim.	R	M		No	
Submitter Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The last name or the organizational name of the entity submitting the transaction	R	NA		Yes	
Submitter Middle Name	1037	Name Middle	AN	1	25	The middle name of the person submitting the transaction	S	NA		Yes	
Subscriber Address Line	166	Address Information	AN	1	55	Address line of the current mailing address of the insured individual or subscriber to the coverage.	S	NA		Yes	COB
Subscriber Birth Date	1251	Date Time Period	AN	1	35	The date of birth of the subscriber to the indicated coverage or policy.	S	NA		Yes	COB
Subscriber City Name	19	City Name	AN	2	30	The City Name of the insured individual or subscriber to the coverage	S	NA		Yes	COB
Subscriber First Name	1036	Name First	AN	1	25	The first name of the insured individual or subscriber to the coverage		NA		Yes	COB
Subscriber Gender Code	1068	Gender Code	ID	1	1	Code indicating the sex of the subscriber to the indicated coverage or policy.		Y		Yes	COB
Subscriber Last Name	1035	Name Last or Organization Name	AN	1	35	The surname of the insured individual or subscriber to the coverage	R	NA		Yes	COB
Subscriber Middle Name	1037	Name Middle	AN	1	25	The middle name of the subscriber to the indicated coverage or policy.	S	NA		Yes	COB
Subscriber Name Suffix	1039	Name Suffix	AN	1	10	Suffix of the insured individual or subscriber to the coverage.	S	NA		Yes	COB
Subscriber Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the insured individual or subscriber to the coverage	S	CL		Yes	COB
Subscriber Primary Identifier	67	Identification Code	AN	2	80	Primary identification number of the subscriber to the coverage.	R/ S	NA		Yes	COB
Subscriber State Code	156	State or Province Code	ID	2	2	The State Postal Code of the insured individual or subscriber to the coverage	S	CL		Yes	COB
Subscriber Supplemental Description	93	Name	AN	1	60	Text information clarifying subscriber additional information	S	NA	This is only required if the name is over 35 characters.	No	COB
Subscriber Supplemental Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the subscriber.	S	NA		No	COB
Tooth Code	1271	Industry Code	AN	1	30	An indication of the tooth on which services were performed or will be performed.	S	CL		Yes	Dental
Tooth Number	127	Reference Identification	AN	1	30	Standard identification number of a tooth.	S	CL		Yes	Dental
Tooth Status Code	1368	Tooth Status Code	ID	1	2	Code specifying the status of a tooth	S	Y		Yes	Dental
Tooth Surface Code	1369	Tooth Surface Code	ID	1	2	The surface(s) of the tooth on which services were performed or will be performed.	S	Y		Yes	Dental
Total Claim Charge Amount	782	Monetary Amount	R	1	18	The sum of all charges included within this claim.	R	NA		No	
Transaction Segment Count	96	Number of Included Segments	NO	1	10	A tally of all segments between the ST and the SE segments including the ST and SE segments.	R	NA		No	
Transaction Set Control Number	329	Transaction Set Control Number	AN	4	9	The unique identification number within a transaction set.	R	NA		No	
Transaction Set Creation Date	373	Date	DT	8	8	Identifies the date the submitter created the transaction	R	NA		No	
Transaction Set Creation Time	337	Time	TM	4	8	Time file is created for transmission.	R	NA		No	

Transaction Set Identifier Code	143	Reference Identification	AN	1	30	Code uniquely identifying a Transaction Set.	R	Y		No	
Transaction Set Purpose Code	353	Transaction Set Purpose Code	ID	2	2	Code identifying purpose of transaction set.	R	Y		No	
Transmission Type Code	127	Reference Identification	AN	1	30	Code identifying the type of transaction or transmission included in the transaction set.	R	Y		No	
Value Added Network Trace Number	127	Reference Identification	AN	1	30	Unique Identification number for a transaction assigned by a Value Added Network, Clearinghouse, or other transmission entity.	S	NA		No	

Client, Provider, or Claim Data	Implementation Guide		Implementation Guide		Implementation Guide	
	837-Institutional	Page #	837-Dental	Page #	837-Professional	Page #
CI			X	161	X	195
CI			X	62	X	70
CP	X	415	X	312	X	367, 566
CI	X	367, 368, 369, 370, 496, 497, 498, 499, 500, 501	X	216, 217, 218, 307, 308, 309, 310, 311	X	327, 328, 329, 330, 560, 561, 562, 563, 564, 565
CI	X	367, 368, 369, 370, 493, 496, 497, 498, 499, 500, 501	X	216, 217, 218, 219, 307, 308, 309, 310, 311	X	327, 328, 329, 330, 331, 560, 561, 562, 563, 564, 565
CI	X	367, 368, 369, 370, 496, 497, 498, 499, 500	X	216, 217, 218, 219, 307, 308, 309, 310, 311	X	326, 327, 328, 329, 330, 560, 561, 562, 563, 564, 565
CI-COB	X	372	X	222	X	334
CI	X	178, 180, 182, 184, 371, 372, 373, 374, 376, 378, 380, 382, 384, 386, 387, 460, 461	X	173, 174, 220, 221, 222, 223, 224, 225, 226, 287	X	219, 220, 221, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 484, 485, 486
CI			X	282		
CI-COB			X	221, 287	X	333, 485
CP	X	444	X	265	X	399
CI	X	175, 454	X	172	X	216
CI	X	174, 453	X	171	X	215, 410
CI	X	174, 454	X	171	X	216, 411

CI	X	162	X	154	X	177
CI-COB	X	160, 390	X	153, 229	X	175, 345
PI	X	84	X	84	X	92
PI			X	79	X	87
PI	X	79	X	80	X	88
PI	X	80	X	81	X	89
PI	X	86	X	86	X	95
PI			X	77	X	85
PI	X	78	X	78	X	86
PI	X	77	X	77	X	85
PI			X	77	X	85
PI			X	77	X	86
PI	X	81	X	82	X	90
PI	X	81	X	82	X	90
CP	X	493	X	304	X	557
CI	X	367, 495	X	216, 307	X	326, 560
CI-COB	X	104, 363	X	101, 211	X	112, 321
CI	X	207	X	186, 288	X	247
CI	X	59	X	56	X	65
CP	X	192	X	180	X	230
CI			X	151		
CI			X	155		
CI	X	228-230, 232-240, 242, 244-254, 256-265, 267- 278, 280-288, 290-305	X	271	X	568

CI	X	65, 66, 88, 89	X	64, 65, 244, 245	X	72, 73, 97, 98, 364, 365, 539, 540
CI	X	65, 66, 88, 89	X	64, 65, 244, 245	X	72, 73, 97, 98, 364, 365, 539, 540
CI	X	65, 88	X	64, 244	X	72, 97, 364, 539
CI			X	100		
CI	X	81, 96, 114, 131, 138, 150, 163, 356, 407, 414	X	82, 93, 110, 142, 154, 237	X	90, 105, 123, 136, 145, 163, 178, 309, 356, 520, 535
CI-COB			X	224		
CI-COB	X	125	X	130	X	150
CI-COB			X	129	X	149
CI-COB	X	122	X	127	X	147
CI-COB	X	122	X	127	X	147
CI-COB	X	122	X	127	X	147
CI-COB	X	184	X	174	X	219
CI-COB	X	123	X	128	X	148
CI	X	74	X	74	X	82
CP			X	246		
CI	X	115, 151, 165, 167, 169, 211, 215, 243, 245-255, 257-266, 268-278, 388, 415, 457, 458, 502	X	111, 143, 157, 158, 160-162, 164, 227, 246, 273, 275, 277, 279, 312	X	115, 124, 155, 164, 180 182, 184, 186, 189, 190, 192, 194, 196, 197, 199-201, 203, 205, 206, 208, 210, 213, 342, 366, 436, 437, 439, 440, 443-445, 447, 450-452, 454, 456, 458, 460, 566

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CI	X	164	X	155	X	179
CI			X	159		
CI	X	62, 68, 74, 77, 92, 109, 122, 127, 135, 145, 322, 329, 336, 343, 350, 401, 410, 421, 425, 429, 433, 437, 441, 463, 470, 477, 484	X	60, 67, 74, 77, 88, 104, 118, 136, 188, 196, 204, 232, 240, 254, 258, 262, 290, 298	X	68, 75, 82, 85, 100, 118, 131, 140, 147, 157, 283, 291, 299, 304, 313, 351, 360, 375, 379, 383, 387, 391, 395, 502, 510, 515, 524, 530, 542, 550
CI	X	62, 68, 77, 92, 109, 122, 127, 135, 146, 322, 329, 336, 343, 350, 401, 411, 421, 425, 429, 433, 437, 441, 463, 470, 477, 484	X	60, 67, 77, 88, 104, 118, 127, 137, 188, 196, 204, 232, 241, 254, 258, 262, 290, 298	X	68, 75, 85, 100, 118, 131, 140, 147, 158, 283, 291, 299, 304, 313, 351, 360, 375, 379, 383, 387, 391, 395, 502, 510, 515, 524, 530, 542, 550
CI			X	127		
CI	X	159	X	151, 268	X	173
CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
CP	X	100, 140	X	97, 133	X	109, 153
CP	X	57	X	54	X	63
CI	X	62, 77, 92, 110, 123, 127, 147, 175, 323, 330, 337, 344, 350, 402, 411, 421, 454, 463, 470, 478, 484	X	60, 67, 78, 89, 105, 118, 128, 137, 172, 189, 197, 204, 233, 241, 254, 291, 298	X	68, 75, 86, 101, 119, 131, 147, 159, 216, 284, 292, 299, 305, 314, 352, 360, 375, 503, 510, 515, 525, 531, 543, 550
CI	X	103, 142, 361	X	100, 134, 210	X	111, 154, 319

CI-COB	X	103	X	100	X	111
CI-COB	X	103, 363	X	100, 210	X	111, 320
PI	X	350	X	204	X	304, 515
PI			X	206	X	306, 517
PI	X	350	X	204	X	305, 516
PI	X	358	X	208	X	311
CP	X	448	X	268	X	402
CP			X	286	X	473
CI			X	127		
CI			X	127		
CI	X	160	X	152	X	174
CI	X	206, 208	X	186, 288	X	247, 488
CI			X	268, 269		
CP	X	58	X	55	X	64
CI			X	163, 278		
CI			X	166		
CI			X	167		
CI-COB	X	409	X	239	X	358
CI-COB			X	234	X	353
CI-COB	X	404, 405	X	235	X	354
CI-COB	X	389	X	228	X	343

CI-COB	X	406	X	236	X	355
CI-COB	X	401	X	232	X	351
CI-COB	X	389	X	228	X	343
CI-COB	X	403	X	233	X	352
CI-COB	X	401	X	232	X	351
CI-COB	X	402	X	232	X	351
CI-COB	X	402	X	232	X	352
CI-COB	X	407	X	237	X	356
CI-COB	X	407	X	237	X	356
CI-COB			X	242	X	362
CI-COB			X	252	X	373
CI-COB			X	244	X	364
CI-COB			X	225	X	337
CI-COB	X	411	X	241, 298	X	360
CI-COB			X	254		
CI-COB	X	371	X	226	X	339
CI-COB	X	421	X	254	X	375
CI-COB			X	256		
CI-COB	X	411	X	241, 302	X	361, 555
CI-COB	X	419	X	249, 300	X	371, 552
CI-COB			X	299		
CI-COB	X	439	X	260	X	381
CI-COB			X	264		
CI-COB	X	417	X	248	X	369

CP			X	303	X	557
CI	X	158	X	150	X	171
CD			X	139	X	160
CD	X	148	X	140	X	161
CD	X	183	X	173	X	220
CD	X	152	X	144	X	165
CD	X	149	X	141	X	162
CD	X	146	X	137	X	158
CD	X	152	X	144	X	165
CD	X	146	X	137	X	158, 375
CD	X	146	X	137	X	158
CD	X	146	X	137	X	158
CD	X	150	X	142	X	163
CD	X	147	X	138	X	159
CI	X	181	X	223		
CD	X	154	X	146	X	167
CD	X	150	X	142	X	162
CI	X	133	X	125	X	138
CI			X	120	X	133
CI	X	129	X	121	X	134
CI	X	130	X	122	X	135
CI	X	128, 491	X	118	X	131
CI	X	127	X	118	X	131, 550
CP			X	220	X	332

CI	X	131	X	123	X	136
CI			X	123		
CI-COB	X	102, 360	X	99, 210	X	110, 319
CI	X	131	X	123	X	136
CI			X	90	X	102
CI	X	94	X	91	X	103
CI	X	95	X	92	X	104
CI			X	88	X	100
CI	X	93	X	89	X	101
CI			X	95	X	107
CI	X	92	X	88	X	100
CI			X	89	X	100
CI			X	89	X	101
CI	X	95	X	93	X	105
CI	X	95	X	93	X	104
CI-COB			X	211		
CI			X	176		
CI			X	276		
CI	X	447, 492	X	267, 302	X	401, 498, 556
CI	X	492	X	303	X	557
CI			X	270		
CI	X	447, 448, 492	X	267, 303	X	401, 402, 556

CI	X	214, 311, 446, 491	X	266, 302	X	401, 498, 555
CI	X	120, 156	X	116, 148	X	129, 169
CI			X	270		
PI	X	71, 324, 331, 338, 345, 352, 465, 472, 479, 486	X	71, 190, 198, 292	X	79, 285, 293, 504, 544
CI	X	160	X	152	X	174
PI	X	72, 325, 332, 339, 346, 353, 466, 473, 480, 487	X	72, 191, 199, 293	X	80, 286, 294, 505, 545
CI	X	306	X	281	X	462
CI			X	167	X	570
CI			X	68	X	76
CI	X	68	X	67	X	75
CI	X	68	X	67	X	75
CP	X	60, 72, 83, 85, 97, 117, 120, 124, 132, 153, 155, 185, 186, 187, 189, 191, 193, 195, 197, 198, 200, 202, 325, 326, 332, 333, 339, 340, 346, 347, 353, 357, 408, 416, 418, 422, 426, 430, 434, 438, 442, 465, 467, 473, 474, 480, 481, 487, 488	X	57, 72, 84, 85, 95, 113, 115, 124, 130, 145, 147, 175, 177, 180, 182, 184, 190, 193, 199, 201, 207, 238, 247, 249, 252, 255, 259, 263, 283, 284, 285, 292, 295, 300	X	66, 80, 92, 94, 106, 126, 128, 137, 150, 166, 168, 222, 224, 226, 228, 230, 232, 233, 235, 236, 239-242, 286, 288, 294, 296, 301, 310, 316, 357, 368, 370, 373, 376, 380, 384, 388, 392, 396, 468-470, 472, 474, 475, 477-480, 483, 504, 507, 512, 521, 527, 536, 545, 547, 552
CI			X	160	X	185, 439
CI			X	182, 284		
CI	X	343, 484	X	188	X	283, 542
CI	X	344	X	189	X	284, 543
CI	X	343, 484	X	188	X	283, 379, 542
CI	X	344, 484	X	189	X	284, 543

CI			X	192	X	287, 546
CI	X	344, 484	X	189	X	284, 543
CI	X	348, 489	X	194	X	289, 548
CI	X	161, 162	X	153, 154	X	176, 177
CI			X	157	X	209
CI	X	161, 391	X	153, 230	X	175, 345
PI			X	196, 290	X	291, 502
PI			X	197, 291	X	292, 503
PI			X	196, 290	X	291, 383, 502
PI			X	196, 290	X	292, 503
PI			X	200, 294	X	295, 506
PI			X	196, 290	X	292, 503
PI			X	202, 296	X	297, 508
CI			X	280		
CI	X	196	X	178	X	223
CI	X	457	X	165, 274	X	436
CP	X	491	X	302	X	555
CI	X	163	X	155	X	178
CD			X	135		
PI	X	65	X	64	X	72
PI	X	62	X	60	X	68

PI	X	63	X	61	X	69
PI	X	62	X	60	X	68
PI	X	62	X	60	X	68
CI-COB	X	112	X	108	X	121
CI-COB	X	116	X	112	X	125
CI-COB	X	113	X	109	X	122
CI-COB	X	109	X	104	X	118
CI-COB	X	116	X	112	X	125
CI-COB	X	109	X	104	X	118
CI-COB	X	109	X	104	X	118
CI-COB	X	110	X	105	X	118
CI-COB	X	114	X	110	X	123
CI-COB	X	110	X	106	X	119
CI-COB	X	114	X	110	X	123
CI-COB			X	107	X	120
CI-COB	X	118	X	114	X	127
CI			X	272		
CI			X	168		
CI			X	168		
CI			X	272		
CP	X	159	X	151	X	172
CP	X	503	X	313	X	572
CP	X	56, 503	X	53, 313	X	62, 572
CP	X	58	X	55	X	64
CP	X	58	X	56	X	65

CP	X	56	X	53	X	62
CP	X	58	X	55	X	64
CP	X	60	X	57	X	66
CP	X	188	X	184		

837-Professional Data Elements						FIELD LENGTH									
Industry Name	Data Element	Element Name	Type	Minimum	Maximum	Element Definition	Required or Situati'	In Impl'tn Guide		Commentary	Currently captured by DMH	Service			
Accident Date	1251	Date Time Period	AN	1	35	Date of the accident related to charges or to the patient's current condition, diagnosis, or treatment referenced in the transaction.	S	NA			No				
Acute Manifestation Date	1251	Date Time Period	AN	1	35	Date of acute manifestation of patient's condition.	S	NA			No				
Additional Submitter Name	93	Name	AN	1	60	Additional name information for the receiver or submitter of the transaction.	S	NA	This is only required if the name is over 35 characters.		No				
Adjudication or Payment Date	1251	Date Time Period	AN	1	35	Date of payment or denial determination by previous payer.	S	NA			No				
Adjusted Repriced Claim Reference Number	127	Reference Identification	AN	1	30	Identification number, assigned by a repricing organization, to identify an adjusted claim.	S	NA			No				
Adjusted Repriced Line Item Reference Number	127	Reference Identification	AN	1	30	Identification number of an adjusted repriced line item adjusted from an original amount.	S	Y			No				
Adjustment Amount	782	Monetary Amount	R	1	18	Adjustment amount for the associated reason code.	R	NA			No				
Adjustment Quantity	380	Quantity	R	1	15	Numeric quantity associated with the related reason code for coordination of benefits.	R	NA			No				
Adjustment Reason Code	1034	Claim Adjustment Reason Code	ID	1	5	Code that indicates the reason for the adjustment.	R	CL			No				
Allowed Amount	782	Monetary Amount	R	1	18	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment.	R	NA			No	COB			
Ambulance Transport Code	1316	Ambulance Transport Code	ID	1	1	Code indicating the type of ambulance transport.	S	Y			No	Ambulan ce			
Ambulance Transport Reason Code	1317	Ambulance Transport Reason Code	ID	1	1	Code indicating the reason for ambulance transport.	S	Y			No	Ambulan ce			
Ambulatory Patient Group Number	127	Reference Identification	AN	1	30	Identifier for Ambulatory Patient Group assigned to the claim.	S	NA			No				
Amount Qualifier Code	522	Amount Qualifier Code	ID	1	3	Code to qualify amount.	S	Y			No				
Anesthesia Modifying Units	380	Quantity	R	1	15	Unit quantity for qualifying extenuating circumstances at time of service.	S	NA			No				

Approved Amount	782	Monetary Amount	R	1	18	Amount approved.	S	NA		No	COB
Arterial Blood Gas Quantity	380	Quantity	R	1	15	The Arterial Blood Gas test results breathing room air (furnish results of recent hospital tests).	S	NA		No	
Assigned Number	554	Assigned Number	N0	1	6	Number assigned for differentiation within a transaction set.	R	NA		No	
Assumed or Relinquished Care Date	1251	Date Time Period	AN	1	35	Date post-operative care was assumed by another provider, or date provider ceased post-operative care.	S	NA		No	
Attachment Control Number	67	Identification Code	AN	2	80	Identification number of attachment related to the claim.	S	M	Needed if there are paper attachments to a claim.	No	
Attachment Report Type Code	755	Report Type Code	ID	2	2	Code to specify the type of attachment that is related to the claim.	S	Y	Needed if there are paper attachments to a claim.	No	
Attachment Transmission Code	756	Report Transmission Code	ID	1	2	Code defining timing, transmission method or format by which an attachment report is to be sent or has been sent.	S	Y	Needed if there are paper attachments to a claim.	No	
Auto Accident State or Province Code	156	State or Province Code	ID	2	2	State or Province where auto accident occurred.	S	CL		No	
Begin Therapy Date	1251	Date Time Period	AN	1	35	Date therapy begins.	S	NA		No	M'care DMERC
Benefits Assignment Certification Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.	R	Y		No	COB
Billing Provider Additional Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the billing provider	S	NA		No	
Billing Provider Additional Name	93	Name	AN	1	60	Additional names or characters for the billing provider or billing entity for the transaction.	S	NA	This is only required if the name is over 35 characters.	No	
Billing Provider Address Line	166	Address Information	AN	1	55	Address line of the billing provider or billing entity address.	R	NA		Yes	
Billing Provider City Name	19	City Name	AN	2	30	City of the billing provider or billing entity	R	NA		Yes	
Billing Provider Contact Name	93	Name	AN	1	60	Person at billing organization to contact regarding the billing transaction.	S	NA		No	
Billing Provider Credit Card Identifier	127	Reference Identification	AN	1	30	Identification number for credit card processing for the billing provider or billing entity	S	NA		No	
Billing Provider First Name	1036	Name First	AN	1	25	First name of the billing provider or billing entity	S	NA		Yes	
Billing Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.	R	NA		Yes	
Billing Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the provider billing or billing entity for services.	R	NA		Yes	
Billing Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the billing provider or billing entity	R	NA		Yes	
Billing Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix, including generation, for the name of the provider or billing entity submitting the claim.	R	NA		Yes	
Billing Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal zone code or ZIP code for the provider or billing entity billing for services.	R	CL		Yes	

Billing Provider State or Province Code	156	State or Province Code	ID	2	2	State or province for provider or billing entity billing for services.	R	CL		Yes	
Bundled or Unbundled Line Number	554	Assigned Number	NO	1	6	Identification of line item bundled or unbundled by payer in coordination of benefits.	S			No	
Certification Condition Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Code indicating whether or not the condition codes apply to the patient or another entity.	S			No	
Certification Period Projected Visit Count	1470	Number	NO	1	9	Total visits projected during this certification period.	S	NA		No	Home Hlth
Certification Revision Date	1251	Date Time Period	AN	1	35	Date the certification was revised.	S	NA		No	
Certification Type Code	1322	Certification Type Code	ID	1	1	Code indicating the type of certification	S	Y		No	
Claim Adjustment Group Code	1033	Claim Adjustment Group Code	ID	1	2	Code identifying the general category of payment adjustment.	S	Y		No	
Claim Filing Indicator Code	1032	Claim Filing Indicator Code	ID	1	2	Code identifying type of claim or expected adjudication process.	S	Y		No	COB
Claim Frequency Code	1325	Claim Frequency Type Code	ID	1	1	Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.	R	M		No	
Claim Note Text	352	Description	AN	1	80	Narrative text providing additional information related to the claim.	S	NA	This is for when you need to note additional information.	No	
Claim or Encounter Identifier	640	Transaction Type Code	ID	2	2	Code indicating whether the transaction is a claim or reporting encounter information.	R	Y		No	
Claim Original Reference Number	127	Reference Identification	AN	1	30	Number assigned by a processor to identify a claim.	S	NA		No	
Clearinghouse Trace Number	127	Reference Identification	AN	1	30	Unique tracking number for the transaction assigned by a clearinghouse.	S	NA		No	
Clinical Laboratory Improvement Amendment Number	127	Reference Identification	AN	1	30	The CLIA Certificate of Waiver or the CLIA Certificate of Registration Identification Number assigned to the laboratory testing site that rendered the services on this claim.	S	NA		No	
Code Category	1136	Code Category	ID	2	2	Specifies the situation or category to which the code applies.	S	Y		No	
Code List Qualifier Code	1270	Code List Qualifier Code	ID	1	3	Code identifying a specific industry code list.	R	Y		No	
Communication Number	364	Communication Number	AN	1	80	Complete communications number including country or area code when applicable	R	NA	This is the biller's phone/fax/e-mail/edi number.	Yes	
Communication Number Qualifier	365	Communication Number Qualifier	ID	2	2	Code identifying the type of communication number	R	Y		No	
Complication Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A code to indicate whether the Patient's condition is Complicated or Uncomplicated.	S	Y		No	Spinal Manip
Condition Code	1321	Condition Indicator	ID	2	2	Code(s) used to identify condition(s) relating to this bill or relating to the patient.	S	Y		No	
Condition Indicator	1321	Condition Indicator	ID	2	2	Code indicating a condition	S	Y		No	

Contact Function Code	366	Contact Function Code	ID	2	2	Code identifying the major duty or responsibility of the person or group named.	R	Y		No	
Contract Amount	782	Monetary Amount	R	1	18	Fixed monetary amount pertaining to the contract	S	NA		Yes	
Contract Code	127	Reference Identification	AN	1	30	Code identifying the specific contract, established by the payer.	S	M		No	
Contract Percentage	332	Percent	R	1	6	Percent of charges payable under the contract	S	NA		No	
Contract Type Code	1166	Contract Type Code	ID	2	2	Code identifying a contract type	S	Y		No	
Contract Version Identifier	799	Version Identifier	AN	1	30	Identification of additional or supplemental contract provisions, or identification of a particular version or modification of contract.	S	M		No	
Co-Pay Status Code	1327	Copay Status Code	ID	1	1	A code indicating the status of the co-payment requirements for this service.	S	Y		No	COB
Country Code	26	Country Code	ID	2	3	Code indicating the geographic location.	S	CL	This is required when the biller's address is outside the United States.	No	
Credit or Debit Card Authorization Number	127	Reference Identification	AN	1	30	Credit/Debit card authorization number used to authorize use of card for payment for billed charges.	S	NA		No	
Credit or Debit Card Holder Additional Name	93	Name	AN	1	60	Additional name information for the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA	This is only required if the name is over 35 characters.	No	
Credit or Debit Card Holder First Name	1036	Name First	AN	1	25	First name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Holder Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Holder Middle Name	1037	Name Middle	AN	1	25	Middle name of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Holder Name Suffix	1039	Name Suffix	AN	1	10	Name suffix of the person or entity who has a credit card that could be used as payment for the billed charges.	S	NA		No	COB
Credit or Debit Card Maximum Amount	782	Monetary Amount	R	1	18	Dollar limit for a credit or debit card	S	NA		No	COB
Credit or Debit Card Number	67	Identification Code	AN	2	80	Credit/Debit card number that may be used to pay for billed charges.	S	NA		No	COB
Currency Code	100	Currency Code	ID	3	3	Code for country in whose currency the charges are specified.	S	CL	Only needed for foreign currency.	No	
Date Time Period Format Qualifier	1250	Date Time Period Format Qualifier	ID	2	3	Code indicating the date format, time format, or date and time format	S	Y	Required when the patient is the same as the subscriber.	No	

Date Time Qualifier	374	Date/Time Qualifier	ID	3	3	Code specifying the type of date or time or both date and time.	S	Y		No	
Delay Reason Code	1514	Delay Reason Code	ID	1	2	Code indicating the reason why a request was delayed.	S	Y		No	
Delivery Pattern Time Code	679	Ship/Delivery Pattern Time Code	ID	1	1	Code which specifies the time delivery pattern of the services..	S	Y		No	Home Hlth
Demonstration Project Identifier	127	Reference Identification	AN	1	30	Identification number for a Medicare demonstration project.	S	Y/NA		No	Demo Projects
Diagnosis Code	1271	Industry Code	AN	1	30	An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition.	R	M	ICD-9 required	Yes	
Diagnosis Code Pointer	1328	Diagnosis Code Pointer	NO	1	2	A pointer to the claim diagnosis code in the order of importance to this service	R	Y		No	
Diagnosis Type Code	1270	Code List Qualifier Code	ID	1	3	Code identifying the type of diagnosis.	S	Y		No	
Disability From Date	1251	Date Time Period	AN	1	35	The beginning date the patient, in the provider's opinion, was or will be unable to perform the duties normally associated with his/her work.	S	NA		No	
Disability To Date	1251	Date Time Period	AN	1	35	The ending date the patient, in the provider's opinion, will be able to perform the duties normally associated with his/her work.	S	NA		No	
Discipline Type Code	921	Discipline Type Code	ID	2	2	Code indicating discipline(s) ordered by the physician.	S	Y		No	Home Hlth
Durable Medical Equipment Duration	380	Quantity	R	1	15	Length of time durable medical equipment (DME) is needed.	S	NA		No	DME
Duration of Visits Units	615	Time Period Qualifier	ID	1	2	The unit (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit every three days occurs over a duration of days.	S	NA		No	Home Hlth
Duration of Visits, Number of Units	616	Number of Periods	NO	1	3	The number of units (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit every three days occurs over a duration of days.	S	NA		No	Home Hlth
Emergency Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not emergency care was rendered in response to the sudden and unexpected onset of a medical condition, a severe injury, or an acute exacerbation of a chronic condition which was threatening to life, limb or sight.	S	NA		No	
End Stage Renal Disease Payment Amount	782	Monetary Amount	R	1	18	Amount of payment under End Stage Renal Disease benefit.	S	NA		No	

Entity Identifier Code	98	Entity Identifier Code	ID	2	3	Code identifying an organizational entity, a physical location, property or an individual	R	Y		No	
Entity Type Qualifier	1065	Entity Type Qualifier	ID	1	1	Code qualifying the type of entity	R	Y		No	
EPSDT Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not Early and Periodic Screening for Diagnosis and Treatment of children services are involved with this detail line.	S	NA		Yes	
Estimated Birth Date	1251	Date Time Period	AN	1	35	Date delivery is expected.	S	NA	For a pregnancy.	No	
Exception Code	1527	Exception Code	ID	1	2	Exception code generated by the Third Party Organization.	S	Y		No	
Facility Type Code	1331	Facility Code Value	AN	1	2	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.	R	Y		No	
Family Planning Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not Family Planning Services are involved with this detail line.	S	Y		No	
Fixed Format Information	449	Fixed Format Information	AN	1	80	Data in fixed format agreed upon by sender and receiver	S	NA	Not used at this time.	No	
Form Identifier	1271	Industry Code	AN	1	30	Letter or number identifying a specific question.	S	M		No	
Frequency Count	1167	Sample Selection Modulus	R	1	6	The count of the frequency units of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit occurs at three day intervals.	S	NA		No	Home Hlth
Frequency Period	355	Unit or Basis for Measurement Code	ID	2	2	The units specifying the frequency of home health visits (e.g., days, months, etc.) Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit occurs at a frequency of days.	S	NA		No	Home Hlth
HCPSC Payable Amount	782	Monetary Amount	R	1	18	Amount due under Medicare HCPSC system.	S	NA		No	M'care Outpatie nt
Hierarchical Child Code	736	Hierarchical Child Code	ID	1	1	Code indicating if there are hierarchical child data segments subordinate to the level being described.	R	Y		No	
Hierarchical ID Number	628	Hierarchical ID Number	AN	1	12	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.	R	NA		No	
Hierarchical Level Code	735	Hierarchical Level Code	ID	1	2	Code defining the characteristic of a level in a hierarchical structure.	R	Y		No	

Hierarchical Parent ID Number	734	Hierarchical Parent ID Number	AN	1	12	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.	R	NA		No	
Hierarchical Structure Code	1005	Hierarchical Structure Code	ID	4	4	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	R	Y		No	
Homebound Indicator	1321	Condition Indicator	ID	2	2	A code indicating whether a patient is homebound.	S	Y		No	
Hospice Employed Provider Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator of whether or not the treatment in the Hospice was rendered by a Hospice employed provider.	S	NA		No	Hospice
Identification Code Qualifier	66	Identification Code Qualifier	ID	1	2	Code designating the system/method of code structure used for Identification Code (67)	R	Y		No	
Immunization Batch Number	127	Reference Identification	AN	1	30	The manufacturer's lot number for vaccine used in immunization.	S	NA		No	Immunizations
Individual Relationship Code	1069	Individual Relationship Code	ID	2	2	Code indicating the relationship between two individuals or entities			Differs from the information in CTRAC	No	
Initial Treatment Date	1251	Date Time Period	AN	1	35	Date that the patient initially sought treatment for this condition.	S	NA		No	
Insurance Type Code	1336	Insurance Type Code	ID	1	3	Code identifying the type of insurance.	S	Y		No	COB
Insured Group Name	93	Name	AN	1	60	Name of the group or plan through which the insurance is provided to the insured.	S	NA		Yes	COB
Insured Group or Policy Number	127	Identification Code	AN	2	80	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	S	NA		No	COB
Insured Individual Death Date	1251	Date Time Period	AN	1	35	Date of death for subscriber or dependent.	S	NA		No	COB
Investigational Device Exemption Identifier	127	Reference Identification	AN	1	30	Number or reference identifying exemption assigned to an investigational device referenced in the claim.	S	NA		No	
Laboratory or Facility Address Line	166	Address Information	AN	1	55	Address line of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	NA		Yes	
Laboratory or Facility City Name	19	City Name	AN	2	30	City of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	NA		Yes	
Laboratory or Facility Name	1035	Name Last or Organization Name	AN	1	35	Name of laboratory or other facility performing Laboratory testing on the claim where the health care service was performed/rendered.	R	NA		Yes	
Laboratory or Facility Name Additional Text	93	Name	AN	1	60	Additional name information identifying the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	S	NA	This is only required if the name is over 35 characters.	No	
Laboratory or Facility Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP or zonal code of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	CL		Yes	

Laboratory or Facility Primary Identifier	67	Identification Code	AN	2	80	Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.	R	NA		No	
Laboratory or Facility Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	S	NA		No	
Laboratory or Facility State or Province Code	156	State or Province Code	ID	2	2	State or province of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	R	CL		Yes	
Last Certification Date	1251	Date Time Period	AN	1	35	The date of the last certification.	S	NA		No	M'care DMERC
Last Menstrual Period Date	1251	Date Time Period	AN	1	35	The date of the last menstrual period (LMP).	S	NA		No	
Last Seen Date	1251	Date Time Period	AN	1	35	Date the patient was last seen by the referring or ordering physician for a claim billed by a provider whose services require physician certification.	S	NA		No	
Last Worked Date	1251	Date Time Period	AN	1	35	Date patient last worked at the patient's current occupation	S	NA		No	
Last X-Ray Date	1251	Date Time Period	AN	1	35	Date patient received last X-Ray.	S	NA		No	
Line Item Charge Amount	782	Monetary Amount	R	1	18	Charges related to this service.	R	NA		No	
Line Item Control Number	127	Reference Identification	AN	1	30	Identifier assigned by the submitter/provider to this line item.	S	NA		No	
Line Note Text	352	Description	AN	1	80	Narrative text providing additional information related to the service line.	S	NA		No	
Mammography Certification Number	127	Reference Identification	AN	1	30	HCFA assigned Certification Number of the certified mammography screening center	S	NA		No	Mammo gram
Measurement Qualifier	738	Measurement Qualifier	ID	1	3	Code identifying a specific product or process characteristic to which a measurement applies	S	Y		No	
Measurement Reference Identification Code	737	Measurement Reference ID Code	ID	2	2	Code identifying the broad category to which a measurement applies	S	Y		No	
Medical Record Number	127	Reference Identification	AN	1	30	A unique number assigned to patient by the provider to assist in retrieval of medical records.	S	NA	Used at discretion of submitter.	No	
Medicare Assignment Code	1359	Provider Accept Assignment Code	ID	1	1	An indication, used by Medicare or other government programs, that the provider accepted assignment.	R/S	Y	Always Required for professional billings. Situational for dental and institutional billings.	No	
Medicare Section 4081 Indicator	127	Reference Identification	AN	1	30	Code indicating Medicare Section 4081 applies.	S	Y	This is only completed by Medicare.	No	COB
Monthly Treatment Count	380	Quantity	R	1	15	Number of treatments rendered in the month of service.	S	NA		No	Spinal Manip
Non-Payable Professional Component Billed Amount	782	Monetary Amount	R	1	18	Amount of non-payable charges included in the bill related to professional services.	S	NA		No	COB
Note Reference Code	363	Note Reference Code	ID	3	3	Code identifying the functional area or purpose for which the note applies.	S	Y		No	
Number of Visits	380	Quantity	R	1	15	The number of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating the number of visits, i.e., one.	S	NA		No	Home Hlth

Onset Date	1251	Date Time Period	AN	1	35	Date of onset of indicated patient condition.	S	NA		No	
Onset of Current Illness or Injury Date	1251	Date Time Period	AN	1	35	Date of onset of indicated patient condition.	S	NA		No	
Order Date	1251	Date Time Period	AN	1	35	Date the service(s) was ordered.	S	NA		No	
Ordering Provider Address Line	166	Address Information	AN	1	55	Address line of the provider ordering services for the patient.	S	NA		No	
Ordering Provider City Name	19	City Name	AN	2	30	City of provider ordering services for the patient	S	NA		No	
Ordering Provider Contact Name	93	Name	AN	1	60	Contact person to whom inquiries should be directed at the provider ordering services for the patient.	S	NA		No	
Ordering Provider First Name	1036	Name First	AN	1	25	The first name of the provider who ordered or prescribed this service.	S	NA		No	
Ordering Provider Identifier	67	Identification Code	AN	2	80	The identifier assigned by the Payer to the provider who ordered or prescribed this service.	S	NA		No	
Ordering Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the provider who ordered or prescribed this service.	S	NA		No	
Ordering Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider ordering services for the patient.	S	NA		No	
Ordering Provider Name Additional Text	93	Name	AN	1	60	Additional name information for the provider ordering services for the patient.	S	NA	This is only required if the name is over 35 characters.	No	
Ordering Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider ordering services for the patient.	S	NA		No	
Ordering Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the provider ordering services for the patient.	S	CL		No	
Ordering Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider ordering services for the patient.	S	NA		No	
Ordering Provider State Code	156	State or Province Code	ID	2	2	The State Postal Code of the provider who ordered / prescribed this service.	S	CL		No	
Originator Application Transaction Identifier	127	Reference Identification	AN	1	30	An identification number that identifies a transaction within the originator's applications system.	R	NA		No	
Other Insured Additional Identifier	127	Reference Identification	AN	1	30	Number providing additional identification of the other insured.	S	NA		No	COB
Other Insured Additional Name	93	Name	AN	1	60	Additional name information for the other insured.	S	NA	This is only required if the name is over 35 characters.	No	COB
Other Insured Address Line	166	Address Information	AN	1	55	Address line of the additional insured individual's mailing address.	S	NA		No	COB
Other Insured Birth Date	1251	Date Time Period	AN	1	35	The birth date of the additional insured individual.	S	NA		No	COB
Other Insured City Name	19	City Name	AN	2	30	The city name of the additional insured individual.	S	NA		No	COB
Other Insured First Name	1036	Name First	AN	1	25	The first name of the additional insured individual.	S	NA		No	COB
Other Insured Gender Code	1068	Gender Code	ID	1	1	A code to specify the sex of the additional insured individual.	S	Y		No	COB
Other Insured Group Name	93	Name	AN	1	60	Name of the group or plan through which the insurance is provided to the other insured.	S	NA		No	COB

Other Insured Identifier	67	Identification Code	AN	2	80	An identification number, assigned by the third party payer, to identify the additional insured individual.	S	NA		No	COB
Other Insured Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the additional insured individual.	S	NA		No	COB
Other Insured Middle Name	1037	Name Middle	AN	1	25	The middle name of the additional insured individual.	S	NA		No	COB
Other Insured Name Suffix	1039	Name Suffix	AN	1	10	The suffix to the name of the additional insured individual.	S	NA		No	COB
Other Insured Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The Postal ZIP code of the additional insured individual's mailing address.	S	CL		No	COB
Other Insured State Code	156	State or Province Code	ID	2	2	The state code of the additional insured individual's mailing address.	S	CL		No	COB
Other Payer Additional Name Text	93	Name	AN	1	60	Additional name information for the other payer organization.	S	NA	This is only required if the name is over 35 characters.	No	COB
Other Payer Claim Adjustment Indicator	127	Reference Identification	AN	1	30	Indicates the other payer has made a previous claim adjustment to this claim.	S	Y		No	COB
Other Payer Contact Name	93	Name	AN	1	60	Name of other payer contact.	S	NA		No	COB
Other Payer Covered Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be covered for the claim for coordination of benefits.	S	NA		No	COB
Other Payer Discount Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be subject to discount provisions.	S	NA		No	COB
Other Payer Identification Number	67	Identification Code	AN	2	80	The non-destination (COB) payer's identification number.	S	NA		No	COB
Other Payer Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The name of the other payer organization.	S	NA		No	COB
Other Payer Patient Paid Amount	782	Monetary Amount	R	1	18	Amount reported by other payer as paid by the patient	S	NA		No	COB
Other Payer Patient Primary Identifier	67	Identification Code	AN	2	80	The non-destination (COB) payer's patient primary identification number.	S	NA		No	COB
Other Payer Patient Responsibility Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be the amount owed by the patient.	S	NA		No	COB
Other Payer Patient Secondary Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's patient secondary identification number(s).	S	NA		No	COB
Other Payer Per Day Limit Amount	782	Monetary Amount	R	1	18	Amount determined by other payer to be the maximum payable per day under the contract.	S	NA		No	COB
Other Payer Pre-Tax Claim Total Amount	782	Monetary Amount	R	1	18	Total claim amount before applying taxes as reported by other payer.	S	NA		No	COB
Other Payer Primary Identifier	67	Identification Code	AN	2	80	An identification number for the other payer.	S	NA		No	COB
Other Payer Prior Authorization or Referral Number	127	Reference Identification	AN	1	30	The non-destination (COB) payer's claim line level prior authorization or referral number.	S	NA		No	COB
Other Payer Purchased Service Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's purchased service provider identifier.	S	NA		No	COB
Other Payer Referring Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's referring provider identifier.	S	NA		No	COB
Other Payer Rendering Provider Secondary Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's rendering provider identifier.	S	NA		No	COB

Other Payer Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the other payer organization	S	NA		No	COB
Other Payer Service Facility Location Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's service facility location identifier.	S	NA		No	COB
Other Payer Supervising Provider Identifier	127	Reference Identification	AN	1	30	The non-destination (COB) payer's supervising provider identifier.	S	NA		No	COB
Other Payer Tax Amount	782	Monetary Amount	R	1	18	Amount of taxes related to the claim as determined By other payer.	S	NA		No	COB
Oxygen Flow Rate	127	Reference Identification	AN	1	30	The oxygen flow rate in liters per minute.	S	Y		No	
Oxygen Saturation Quantity	380	Quantity	R	1	15	The oxygen saturation (oximetry) test results.	S	Y		No	Home Hlth
Oxygen Saturation Test Date	1251	Date Time Period	AN	1	35	Date patient received oxygen saturation test.	S	NA		No	
Oxygen Test Condition Code	1349	Oxygen Test Condition Code	ID	1	1	Code indicating the conditions under which a patient was tested.	S	Y		No	Home Hlth
Oxygen Test Findings Code	1350	Oxygen Test Findings Code	ID	1	1	Code indicating the findings of oxygen tests performed on a patient.	S	Y		No	Home Hlth
Paid Service Unit Count	380	Quantity	R	1	15	Units of service paid by the payer for coordination of benefits.	S	NA		No	
Participation Agreement	1360	Provider Agreement Code	ID	1	1	Code indicating a participating claim submitted by a non-participating provider.	S	Y		No	
Patient Account Number	1028	Claim Submitter's Identifier	AN	1	38	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim.	R	NA		No	
Patient Additional Name	93	Name	AN	1	60	Additional name information for the patient.	S	NA	This is only required if the name is over 35 characters.	No	
Patient Address Line	166	Address Information	AN	1	55	Address line of the street mailing address of the patient.	R	NA		Yes	
Patient Amount Paid	782	Monetary Amount	R	1	18	The amount the provider has received from the patient (or insured) toward payment of this claim.	S	NA		Yes	
Patient Birth Date	1251	Date Time Period	AN	1	35	Date of birth of the patient.	R	NA		Yes	
Patient City Name	19	City Name	AN	2	30	The city name of the patient.	R	NA		Yes	
Patient Condition Code	1342	Nature of Condition Code	ID	1	1	Code indicating the condition of the patient.	R	Y		No	Spinal Manip
Patient Condition Description	352	Description	AN	1	80	Free-form description of the patient's condition.	R	NA		No	Spinal Manip
Patient Death Date	1251	Date Time Period	AN	1	35	Date of the patient's death.	S	NA		Yes	
Patient First Name	1036	Name First	AN	1	25	The first name of the individual to whom the services were provided.	R	NA		Yes	
Patient Gender Code	1068	Gender Code	ID	1	1	A code indicating the sex of the patient.	R	Y		Yes	
Patient Last Name	1035	Name Last or Organization Name	AN	1	35	The last name of the individual to whom the services were provided.	R	NA		Yes	
Patient Middle Name	1037	Name Middle	AN	1	25	The middle name of the individual to whom the services were provided.	R	NA		Yes	

Patient Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the individual to whom the services were provided.	R	NA		Yes	
Patient Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the patient.	R	CL		Yes	
Patient Primary Identifier	67	Identification Code	AN	2	80	Identifier assigned by the payer to identify the patient	R	NA		No	
Patient Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier assigned to the patient by the payer.	S	NA		No	
Patient Signature Source Code	1351	Patient Signature Source Code	ID	1	1	Code indication how the patient/subscriber authorization signatures were obtained and how they are being retained by the provider.	S	Y		No	
Patient State Code	156	State or Province Code	ID	2	2	The State Postal Code of the patient.	R	CL		Yes	
Patient Weight	81	Weight	R	1	10	Weight of the patient at time of treatment or transport.	S	NA		No	
Payer Additional Identifier	127	Reference Identification	AN	1	30	Additional identifier for the payer.	S	NA		No	
Payer Additional Name	93	Name	AN	1	60	Additional name information for the payer.	S	NA	This is only required if the name is over 35 characters.	No	
Payer Address Line	166	Address Information	AN	1	55	Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	NA		Yes	
Payer City Name	19	City Name	AN	2	30	The City Name of the Payer's claim mailing address for this particular payer ID and claim office.	S	NA		Yes	
Payer Identifier	67	Identification Code	AN	2	80	Number identifying the payer organization.	R	NA		Yes	
Payer Name	1035	Name Last or Organization Name	AN	1	35	Name identifying the payer organization.	R	NA		Yes	
Payer Paid Amount	782	Monetary Amount	R	1	18	The amount paid by the payer on this claim.	S	NA		Yes	
Payer Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.	S	CL		Yes	
Payer Responsibility Sequence Number Code	1138	Payer Responsibility Sequence Number Code	ID	1	1	Code identifying the insurance carrier's level of responsibility for a payment of a claim	R	Y		No	COB
Payer State Code	156	State or Province Code	ID	2	2	State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.	S	CL		Yes	
Pay-to Provider Additional Name	93	Name	AN	1	60	Additional name information for the provider to receive payment.	S	NA	This is only required if the name is over 35 characters.	No	
Pay-to Provider Address Line	166	Address Information	AN	1	55	Address line of the provider to receive payment	S	NA		Yes	
Pay-to Provider City Name	19	City Name	AN	2	30	City name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider First Name	1036	Name First	AN	1	25	First name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider Identifier	67	Identification Code	AN	2	80	Identification number for the provider or organization that will receive payment.	S	NA		Yes	
Pay-to Provider Identifier	127	Reference Identification	AN	1	30	Identification number for the provider or organization that will receive payment.	S	NA		No	

Pay-to Provider Last or Organizational Name	1035	Name Last or Organization Name	AN	1	35	Last or organizational name of the provider to receive payment.	S	NA		Yes	
Pay-to Provider Middle Name	1037	Name Middle	AN	1	25	The middle name of the pay-to provider.	S	NA		Yes	
Pay-to Provider Name Suffix	1039	Name Suffix	AN	1	10	The suffix, including generation, of the provider that will receive payment.	S	NA		Yes	
Pay-to Provider Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the provider to receive payment	S	CL		Yes	
Pay-to Provider State Code	156	State or Province Code	ID	2	2	State of the provider to receive payment.	S	CL		Yes	
Place of Service Code	1331	Facility Code Value	AN	1	2	The code that identifies where the service was performed.	S	Y		No	
Policy Compliance Code	1526	Policy Compliance Code	ID	1	2	The code that specifies policy compliance.	S	Y		No	
Postage Claimed Amount	782	Monetary Amount	R	1	18	Cost of postage used to provide service or to process associated paper work.	S	NA		No	
Pregnancy Indicator	1073	Yes/No Condition or Response Code	ID	1	1	A yes/no code indicating whether a patient is pregnant.	S	Y		No	
Prescription Date	1251	Date Time Period	AN	1	35	The date the prescription was issued by the referring physician.	S	NA		Yes	
Prescription Number	127	Reference Identification	AN	1	30	The unique identification number assigned by the pharmacy or supplier to the prescription.	S	NA		Yes	
Pricing Methodology	1473	Pricing Methodology	ID	2	2	Pricing methodology at which the claim or line item has been priced or repriced.	S	Y		No	
Prior Authorization or Referral Number	127	Reference Identification	AN	1	30	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved.	S	NA		No	
Procedure Code	234	Product/Service ID	AN	1	48	Code identifying the procedure, product or service.	R	CL		Yes	
Procedure Code Description	352	Description	AN	1	80	Description clarifying the Product/Service Procedure Code and related data elements.	S	NA		Yes	
Procedure Modifier	1339	Procedure Modifier	AN	2	2	This identifies special circumstances related to the performance of the service.	S	Y		No	
Product or Service ID Qualifier	235	Product/Service ID Qualifier	ID	2	2	Code identifying the type/source of the descriptive number used in Product/Service ID (234).	R/CL/S	Y		No	
Property Casualty Claim Number	127	Reference Identification	AN	1	30	Identification number for property casualty claim associated with the services identified on the bill.	S	NA		No	
Provider Code	1221	Provider Code	ID	1	3	Code identifying the type of provider.	R/S	Y		No	
Provider or Supplier Signature Indicator	1073	Yes/No Condition or Response Code	ID	1	1	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office.	R	Y		No	
Provider Taxonomy Code	127	Reference Identification	AN	1	30	Code designating the provider type, classification, and specialization.	S	CL		No	
Purchased Service Charge Amount	782	Monetary Amount	R	1	18	The charge for the purchased service.	S	NA		No	

Purchased Service Provider Identifier	67	Reference Identification	AN	1	30	The provider number of the entity from which service was purchased.	S	NA		No	
Purchased Service Provider Identifier	127						S	NA		No	
Purchased Service Provider Name	1035	Name Last or Organization Name	AN	1	35	The name of the provider of the purchased service.	S	NA		No	
Purchased Service Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider of purchased services.	S	NA		No	
Quantity Qualifier	673	Quantity Qualifier	ID	2	2	Code specifying the type of quantity	S	Y		No	
Question Number/Letter	350	Assigned Identification	AN	1	20	Identifies the question or letter number.	R	NA		No	
Question Response	1073	Yes/No Condition or Response Code	ID	1	1	A yes/no question response.	S	Y		No	
Question Response	127	Reference Identification	AN	1	30	A yes/no question response.	S	NA/Y		No	
Question Response	332	Percent	R	1	6	A yes/no question response.	S	NA		No	
Question Response	373	Date	DT	8	8	A yes/no question response.	S	NA		No	
Receiver Additional Name	93	Name	AN	1	60	Additional name information for the receiver.	S	NA	This is only required if the name is over 35 characters.	No	
Receiver Name	1035	Name Last or Organization Name	AN	1	35	Name of organization receiving the transaction.	R	NA		No	
Receiver Primary Identifier	67	Identification Code	AN	2	80	Primary identification number for the receiver of the transaction.	R	NA		No	
Reference Identification Qualifier	128	Reference Identification Qualifier	ID	2	3	Code qualifying the reference identification	R/S	Y		No	
Referral Date	1251	Date Time Period	AN	1	35	Date of referral.	S	NA		No	
Referring CLIA Number	127	Reference Identification	AN	1	30	Referring CLIA number.	S	NA		No	
Referring Provider First Name	1036	Name First	AN	1	25	The first name of provider who referred the patient to the provider of service on this claim.	S	NA		No	
Referring Provider Identifier	67	Identification Code	AN	2	80	The identification number for the referring physician.	S	NA		No	
Referring Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of Provider who referred the patient to the provider of service on this claim.	S	NA		No	
Referring Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider who is referring patient for care.	S	NA		No	

Referring Provider Name Additional Text	93	Name	AN	1	60	Additional name information identifying the referring provider.	S	NA	This is only required if the name is over 35 characters.	No	
Referring Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider referring the patient for care.	S	NA		No	
Referring Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identification number for the provider referring the patient for service.	S	NA		No	
Reimbursement Rate	954	Percent	R	1	10	Rate used when payment is based upon a percentage of applicable charges.	S	NA		No	COB
Reject Reason Code	901	Reject Reason Code	ID	2	2	Code assigned by issuer to identify reason for rejection	S	Y		No	
Related Causes Code	1362	Related-Causes Code	ID	2	3	Code identifying an accompanying cause of an illness, injury, or an accident.	R/S	Y		No	
Related Hospitalization Admission Date	1251	Date Time Period	AN	1	35	The date the patient was admitted for inpatient care related to current service.	S	NA		No	
Related Hospitalization Discharge Date	1251	Date Time Period	AN	1	35	The date the patient was discharged from the inpatient care referenced in the applicable hospitalization or hospice date.	S	NA		No	
Release of Information Code	1363	Release of Information Code	ID	1	1	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.	R	Y		No	
Remark Code	127	Reference Identification	AN	1	30	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list.	S	Y		No	COB
Rendering Provider First Name	1036	Name First	AN	1	25	The first name of the provider who performed the service.	S	NA		Yes	
Rendering Provider Identifier	67	Identification Code	AN	2	80	The identifier assigned by the Payor to the provider who performed the service.	S	NA		Yes	
Rendering Provider Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The last name or organization of the provider who performed the service	S	NA		Yes	
Rendering Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider who has provided the services to the patient.	S	NA		Yes	
Rendering Provider Name Additional Text	93	Name	AN	1	60	Additional name information identifying the rendering provider.	S	NA	This is only required if the name is over 35 characters.	No	
Rendering Provider Name Suffix	1039	Name Suffix	AN	1	10	Name suffix of the provider who has provided the services to the patient.	S	NA		Yes	
Rendering Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider providing care to the patient.	S	NA		Yes	
Repriced Allowed Amount	782	Monetary Amount	R	1	18	The maximum amount determined by the repricer as being allowable under the provisions of the contract prior to the determination of the actual payment.	S	NA		No	
Repriced Approved Ambulatory Patient Group Amount	782	Monetary Amount	R	1	18	Amount of payment by the repricer for the referenced Ambulatory Patient Group.	S	NA		No	
Repriced Approved Ambulatory Patient Group Code	127	Reference Identification	AN	1	30	Identifier for Ambulatory Patient Group assigned to the claim by the repricer.	S	M		No	

Repriced Approved Service Unit Count	380	Quantity	R	1	15	Number of service units approved by pricing or repricing entity.	S	NA		No	
Repriced Claim Reference Number	127	Reference Identification	AN	1	30	Identification number, assigned by a repricing organization, to identify the claim.	S	NA		No	
Repriced Line Item Reference Number	127	Reference Identification	AN	1	30	Identification number of a line item repriced by a third party or prior payer.	S	NA		No	
Repriced Saving Amount	782	Monetary Amount	R	1	18	The amount of savings related to Third Party Organization claims.	S	NA		No	
Repricing Organization Identifier	127	Reference Identification	AN	1	30	Reference or identification number of the repricing organization.	S	NA		No	
Repricing Per Diem or Flat Rate Amount	118	Rate	R	1	9	Amount used to determine the flat rate or per diem price by the repricing organization.	S	NA		No	
Responsible Party Additional Name	93	Name	AN	1	60	Additional name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	S	NA	This is only required if the name is over 35 characters.	No	
Responsible Party Address Line	166	Address Information	AN	1	55	Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party City Name	19	City Name	AN	2	30	City name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party First Name	1036	Name First	AN	1	25	First name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	Last name or organization name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party Middle Name	1037	Name Middle	AN	1	25	Middle name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	
Responsible Party Postal Zone or ZIP Code	116	Postal Code	ID	3	15	Postal ZIP code of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	CL		Yes	
Responsible Party State Code	156	State or Province Code	ID	2	2	State or province of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations.	R	CL		Yes	
Responsible Party Suffix Name	1039	Name Suffix	AN	1	10	Suffix for name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..	R	NA		Yes	

Round Trip Purpose Description	352	Description	AN	1	80	Free-form description of the purpose of the ambulance transport round trip.	S	NA		No	Ambulance
Sales Tax Amount	782	Monetary Amount	R	1	18	Amount of sales tax attributable to the referenced Service.	S	NA		No	
Service Authorization Exception Code	127	Reference Identification	AN	1	30	Code identifying the service authorization exception.	S	Y	Required when a service is provided without required prior authorization.	No	
Service Date	373	Date Time Period	AN	1	35	Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.	R/S	NA		Yes	
Service Facility Location Secondary Identifier	127	Reference Identification	AN	1	30	Secondary identifier for service facility location.	S	NA		No	
Service Facility Name	1035	Name Last or Organization Name	AN	1	35	Name for service facility.	S	NA		Yes	
Service Line Paid Amount	782	Monetary Amount	R	1	18	Amount paid by the indicated payer for a service line	S	NA		No	
Service Unit Count	380	Quantity	R	1	15	The quantity of units, times, days, visits, services, or treatments for the service described by the HCPCS codes, revenue code or procedure code.	R	NA		Yes	
Ship, Delivery or Calendar Pattern Code"	678	Ship/Delivery or Calendar Pattern Code	ID	1	2	The time delivery pattern for the services.	S	Y		No	Home Hlth
Shipped Date	1251	Date Time Period	AN	1	35	Date product shipped.	S	NA		No	
Similar Illness or Symptom Date	1251	Date Time Period	AN	1	35	Date of onset of a similar illness or symptom.	S	NA		No	
Special Program Indicator	1366	Special Program Code	ID	2	3	A code indicating the Special Program under which the services rendered to the patient were performed.	S	Y		No	
Stretcher Purpose Description	352	Description	AN	1	80	Free-form description of the purpose of the use of a stretcher during ambulance service.	S	NA		No	Ambulance
Subluxation Level Code	1367	Subluxation Level Code	ID	2	3	Code identifying the specific level of subluxation.	S	Y		No	Spinal Manip
Submitter Contact Name	93	Name	AN	1	60	Name of the person at the submitter organization to whom inquiries about the transaction should be directed.	R	NA		No	
Submitter First Name	1036	Name First	AN	1	25	The first name of the person submitting the transaction or receiving the transaction, as identified by the preceding identification code.	S	NA		Yes	
Submitter Identifier	67	Identification Code	AN	2	80	Code or number identifying the entity submitting the claim.	R	M		No	
Submitter Last or Organization Name	1035	Name Last or Organization Name	AN	1	35	The last name or the organizational name of the entity submitting the transaction	R	NA		Yes	
Submitter Middle Name	1037	Name Middle	AN	1	25	The middle name of the person submitting the transaction	S	NA		Yes	
Subscriber Address Line	166	Address Information	AN	1	55	Address line of the current mailing address of the insured individual or subscriber to the coverage.	S	NA		Yes	COB
Subscriber Birth Date	1251	Date Time Period	AN	1	35	The date of birth of the subscriber to the indicated coverage or policy.	S	NA		Yes	COB
Subscriber City Name	19	City Name	AN	2	30	The City Name of the insured individual or subscriber to the coverage	S	NA		Yes	COB

Subscriber First Name	1036	Name First	AN	1	25	The first name of the insured individual or subscriber to the coverage	NA		Yes	COB
Subscriber Gender Code	1068	Gender Code	ID	1	1	Code indicating the sex of the subscriber to the indicated coverage or policy.	Y		Yes	COB
Subscriber Last Name	1035	Name Last or Organization Name	AN	1	35	The surname of the insured individual or subscriber to the coverage	R NA		Yes	COB
Subscriber Middle Name	1037	Name Middle	AN	1	25	The middle name of the subscriber to the indicated coverage or policy.	S NA		Yes	COB
Subscriber Name Suffix	1039	Name Suffix	AN	1	10	Suffix of the insured individual or subscriber to the coverage.	S NA		Yes	COB
Subscriber Postal Zone or ZIP Code	116	Postal Code	ID	3	15	The ZIP Code of the insured individual or subscriber to the coverage	S CL		Yes	COB
Subscriber Primary Identifier	67	Identification Code	AN	2	80	Primary identification number of the subscriber to the coverage.	R/ S NA		Yes	COB
Subscriber State Code	156	State or Province Code	ID	2	2	The State Postal Code of the insured individual or subscriber to the coverage	S CL		Yes	COB
Subscriber Supplemental Description	93	Name	AN	1	60	Text information clarifying subscriber additional information	S NA	This is only required if the name is over 35 characters.	No	COB
Subscriber Supplemental Identifier	127	Reference Identification	AN	1	30	Identifies another or additional distinguishing code number associated with the subscriber.	S NA		No	COB
Supervising Provider First Name	1036	Name First	AN	1	25	The First Name of the Provider who supervised the rendering of a service on this claim.	S NA		No	
Supervising Provider Identifier	67	Identification Code	AN	2	80	The Identification Number for the Supervising Provider.	S NA		No	
Supervising Provider Last Name	1035	Name Last or Organization Name	AN	1	35	The Last Name of the Provider who supervised the rendering of a service on this claim.	S NA		No	
Supervising Provider Middle Name	1037	Name Middle	AN	1	25	Middle name of the provider supervising care rendered to the patient.	S NA		No	
Supervising Provider Name Additional Text	93	Name	AN	1	60	Additional name information of the provider supervising care rendered to the patient.	S NA	This is only required if the name is over 35 characters.	No	
Supervising Provider Name Suffix	1039	Name Suffix	AN	1	10	Suffix to the name of the provider supervising care rendered to the patient.	S NA		No	
Supervising Provider Secondary Identifier	127	Reference Identification	AN	1	30	Additional identifier for the provider supervising care rendered to the patient.	S NA		No	
Terms Discount Percentage	338	Terms Discount Percent	R	1	6	Discount percentage available to the payer for payment within a specific time period.	S NA		No	
Test Performed Date	1251	Date Time Period	AN	1	35	The date the patient was tested for arterial blood. gas and/or oxygen saturation on room air.	S NA		No	
Test Results	739	Measurement Value	R	1	20	If tests are performed under other conditions such as oxygen, give test results and information necessary for interpreting the tests and why performed under these conditions.	S NA		No	
Total Claim Charge Amount	782	Monetary Amount	R	1	18	The sum of all charges included within this claim.	R NA		No	
Total Purchased Service Amount	782	Monetary Amount	R	1	18	Amount of charges associated with the claim attributable to purchased services	S NA	Pertains to subcontracted services.	No	
Total Visits Rendered Count	1470	Number	NO	1	9	Total visits on this bill rendered prior to re-certification date.	S NA		No	Home Hlth

Transaction Segment Count	96	Number of Included Segments	N0	1	10	A tally of all segments between the ST and the SE segments including the ST and SE segments.	R	NA		No	
Transaction Set Control Number	329	Transaction Set Control Number	AN	4	9	The unique identification number within a transaction set.	R	NA		No	
Transaction Set Creation Date	373	Date	DT	8	8	Identifies the date the submitter created the transaction	R	NA		No	
Transaction Set Creation Time	337	Time	TM	4	8	Time file is created for transmission.	R	NA		No	
Transaction Set Identifier Code	143	Reference Identification	AN	1	30	Code uniquely identifying a Transaction Set.	R	Y		No	
Transaction Set Purpose Code	353	Transaction Set Purpose Code	ID	2	2	Code identifying purpose of transaction set.	R	Y		No	
Transmission Type Code	127	Reference Identification	AN	1	30	Code identifying the type of transaction or transmission included in the transaction set.	R	Y		No	
Transport Distance	380	Quantity	R	1	15	Distance traveled during the ambulance transport.	S	NA		No	Ambulan ce
Treatment Count	380	Quantity	R	1	15	Total number of treatments in the series.	S	NA		No	Spinal Manip
Treatment Period Count	380	Quantity	R	1	15	The number of time periods during which treatment will be provided to patient.	S	NA		No	Spinal Manip
Treatment Series Number	609	Count	N0	1	9	Number this treatment is in the series of services.	S	NA		No	Spinal Manip
Unit or Basis for Measurement Code	355	Unit or Basis for Measurement Code	ID	2	2	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	S	Y		No	
Universal Product Number	127	Reference Identification	AN	1	30	Industry standard code identifying supplies and materials.	S	NA		No	
Visits	673	Quantity Qualifier	ID	2	2	The unit for home health visitations. Example: One visit every three days for 21 days. This element qualifies that the data is communicating visits.	S	NA		No	Home Hlth
Work Return Date	1251	Date Time Period	AN	1	35	Date patient was or is able to return to the patient's normal occupation or to a similar or substitute occupation.	S	NA		No	
X-ray Availability Indicator	1073	Yes/No Condition or Response Code	ID	1	1	Indicates if X-Rays are on file for chiropractor spinal manipulation.	S	Y		No	Spinal Manip

Client, Provider, or Claim Data	Implementation Guide		Implementation Guide		Implementation Guide	
	837-Institutional	Page #	837-Dental	Page #	837-Professional	Page #
CI			X	161	X	195
CI					X	191, 457
CI			X	62	X	70
CP	X	415	X	312	X	367, 566
CI-CR	X	185			X	235
CI-CR					X	469
CI	X	367, 368, 369, 370, 496, 497, 498, 499, 500, 501	X	216, 217, 218, 307, 308, 309, 310, 311	X	327, 328, 329, 330, 560, 561, 562, 563, 564, 565
CI	X	367, 368, 369, 370, 493, 496, 497, 498, 499, 500, 501	X	216, 217, 218, 219, 307, 308, 309, 310, 311	X	327, 328, 329, 330, 331, 560, 561, 562, 563, 564, 565
CI	X	367, 368, 369, 370, 496, 497, 498, 499, 500	X	216, 217, 218, 219, 307, 308, 309, 310, 311	X	326, 327, 328, 329, 330, 560, 561, 562, 563, 564, 565
CI-COB	X	372	X	222	X	334
CI					X	249
CI					X	249, 413
CI					X	240, 479
CI	X	178, 180, 182, 184, 371, 372, 373, 374, 376, 378, 380, 382, 384, 386, 387, 460, 461	X	173, 174, 220, 221, 222, 223, 224, 225, 226, 287	X	219, 220, 221, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 484, 485, 486
CI					X	463

CI-COB			X	221, 287	X	333, 485
CI					X	424
CP	X	444	X	265	X	399
CI					X	213
CI	X	175, 454	X	172	X	216
CI	X	174, 453	X	171	X	215, 410
CI	X	174, 454	X	171	X	216, 411
CI	X	162	X	154	X	177
CI					X	441
CI-COB	X	160, 390	X	153, 229	X	175, 345
PI	X	84	X	84	X	92
PI			X	79	X	87
PI	X	79	X	80	X	88
PI	X	80	X	81	X	89
PI	X	88			X	97
PI	X	86	X	86	X	95
PI			X	77	X	85
PI	X	78	X	78	X	86
PI	X	77	X	77	X	85
PI			X	77	X	85
PI			X	77	X	86
PI	X	81	X	82	X	90

PI	X	81	X	82	X	90
CP	X	493	X	304	X	557
CI	X	219			X	258, 261, 264, 428, 433
CI-HH					X	277
CI					X	438
CI	X	213			X	421, 424
CI	X	367, 495	X	216, 307	X	326, 560
CI-COB	X	104, 363	X	101, 211	X	112, 321
CI	X	159			X	173
CI	X	207	X	186, 288	X	247
CI	X	59	X	56	X	65
CP	X	192	X	180	X	230
CP					X	239
CI					X	232, 476
CI	X	218			X	257, 260, 263, 427, 431, 433
CI	X	228-230, 232-240, 242, 244-254, 256-265, 267- 278, 280-288, 290-305	X	271	X	568
CI	X	65, 66, 88, 89	X	64, 65, 244, 245	X	72, 73, 97, 98, 364, 365, 539, 540
CI	X	65, 66, 88, 89	X	64, 65, 244, 245	X	72, 73, 97, 98, 364, 365, 539, 540
CI-SM					X	255, 419
CI					X	258, 259, 261, 262, 428, 429
CI					X	431, 433, 434

CI	X	65, 88	X	64, 244	X	72, 97, 364, 539
CI	X	177			X	218, 467
CI	X	177			X	218, 467
CI	X	177			X	218, 467
CI	X	176			X	217, 466
CI	X	177			X	218, 467
CI-COB					X	407
CI	X	81, 96, 114, 131, 138, 150, 163, 356, 407, 414	X	82, 93, 110, 142, 154, 237	X	90, 105, 123, 136, 145, 163, 178, 309, 356, 520, 535
CI-COB	X	125	X	130	X	150
CI-COB			X	129	X	149
CI-COB	X	122			X	147
CI-COB	X	122	X	127	X	147
CI-COB	X	122	X	127	X	147
CI-COB	X	122	X	127	X	147
CI-COB	X	184	X	174	X	219
CI-COB	X	123	X	128	X	148
CI	X	74	X	74	X	82
CI	X	115, 151, 165, 167, 169, 211, 215, 243, 245-255, 257-266, 268-278, 388, 415, 457, 458, 502	X	111, 143, 157, 158, 160-162, 164, 227, 246, 273, 275, 277, 279, 312	X	115, 124, 155, 164, 180 182, 184, 186, 189, 190, 192, 194, 196, 197, 199-201, 203, 205, 206, 208, 210, 213, 342, 366, 436, 437, 439, 440, 443-445, 447, 450-452, 454, 456, 458, 460, 566

CI	X	165, 167, 169, 415, 456, 458, 502	X	157, 158, 160-162, 164, 246, 273, 275, 277, 279, 312	X	180, 182, 184, 186, 188, 190, 192, 194, 196, 197, 199-201, 203, 205, 206, 208, 210, 213, 366, 435, 437, 439, 440, 442, 444, 445, 447, 449, 451, 452, 454, 456, 458, 460, 566
CI	X	164	X	155	X	179
CI-HH	X	320			X	281, 494
CI	X	202			X	243
CI					X	266-270
CI					X	405
CI					X	266-270
CI					X	202
CI					X	204
CI-HH	X	314			X	276
CI					X	422
CI-HH	X	318			X	280, 493
CI-HH	X	318			X	280, 493
CI					X	406
CI					X	349

CI	X	62, 68, 74, 77, 92, 109, 122, 127, 135, 145, 322, 329, 336, 343, 350, 401, 410, 421, 425, 429, 433, 437, 441, 463, 470, 477, 484	X	60, 67, 74, 77, 88, 104, 118, 136, 188, 196, 204, 232, 240, 254, 258, 262, 290, 298	X	68, 75, 82, 85, 100, 118, 131, 140, 147, 157, 283, 291, 299, 304, 313, 351, 360, 375, 379, 383, 387, 391, 395, 502, 510, 515, 524, 530, 542, 550
CI	X	62, 68, 77, 92, 109, 122, 127, 135, 146, 322, 329, 336, 343, 350, 401, 411, 421, 425, 429, 433, 437, 441, 463, 470, 477, 484	X	60, 67, 77, 88, 104, 118, 127, 137, 188, 196, 204, 232, 241, 254, 258, 262, 290, 298	X	68, 75, 85, 100, 118, 131, 140, 147, 158, 283, 291, 299, 304, 313, 351, 360, 375, 379, 383, 387, 391, 395, 502, 510, 515, 524, 530, 542, 550
CI					X	406
CI					X	199
CI	X	313			X	275, 500
CI	X	159	X	151, 268	X	173
CI					X	406
CI	X	204			X	245, 487
CI					X	568
CI-HH	X	318			X	280, 493
CI-HH	X	317			X	279, 492
CP					X	348
CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153
CP	X	70, 100, 140	X	70, 97, 133	X	78, 109, 153

CP	X	100, 140	X	97, 133	X	109, 153
CP	X	57	X	54	X	63
CI					X	264
CI					X	431
CI	X	62, 77, 92, 110, 123, 127, 147, 175, 323, 330, 337, 344, 350, 402, 411, 421, 454, 463, 470, 478, 484	X	60, 67, 78, 89, 105, 118, 128, 137, 172, 189, 197, 204, 233, 241, 254, 291, 298	X	68, 75, 86, 101, 119, 131, 147, 159, 216, 284, 292, 299, 305, 314, 352, 360, 375, 503, 510, 515, 525, 531, 543, 550
CI					X	478
CI	X	103, 142, 361	X	100, 134, 210	X	111, 154, 319
CI					X	183, 459
CI-COB					X	111, 321
CI-COB	X	103	X	100	X	111
CI-COB	X	103, 363	X	100, 210	X	111, 320
CI-COB					X	115
CI	X	193			X	236
PI	X	354			X	307, 518
PI	X	355			X	308, 519
PI	X	350	X	204	X	304, 515
PI			X	206	X	306, 517
PI	X	356			X	309, 520

PI	X	350	X	204	X	305, 516
PI	X	358	X	208	X	311
PI	X	355			X	309, 520
CI					X	443
CI					X	196
CI					X	187, 446
CI					X	205
CI					X	198, 455
CP	X	448	X	268	X	402
CP			X	286	X	473
CI					X	488
CI					X	226, 474
CI					X	465
CI					X	465
CI	X	201			X	241
CI	X	160	X	152	X	174
CI-COB					X	225
CI-SM					X	255, 419
CI-COB					X	349
CI	X	206, 208	X	186, 288	X	247, 488
CI-HH	X	317			X	279, 492

CI					X	453
CI					X	189
CI					X	181, 444
PI					X	533
PI					X	534
PI					X	539
PI					X	530
PI					X	531
PI					X	530
PI					X	530
PI					X	532
PI					X	530
PI					X	535
PI					X	537
PI					X	535
CP	X	58	X	55	X	64
CI-COB	X	409	X	239	X	358
CI-COB			X	234	X	353
CI-COB	X	404, 405	X	235	X	354
CI-COB	X	389	X	228	X	343
CI-COB	X	406	X	236	X	355
CI-COB	X	401	X	232	X	351
CI-COB	X	389	X	228	X	343
CI-COB	X	363			X	320

CI-COB	X	403	X	233	X	352
CI-COB	X	401	X	232	X	351
CI-COB	X	402	X	232	X	351
CI-COB	X	402	X	232	X	352
CI-COB	X	407	X	237	X	356
CI-COB	X	407	X	237	X	356
CI-COB			X	242	X	362
CI-COB			X	252	X	373
CI-COB			X	244	X	364
CI-COB					X	336
CI-COB			X	225	X	337
CI-COB					X	551
CI-COB	X	411	X	241, 298	X	360
CI-COB	X	371	X	226	X	339
CI-COB	X	421	X	254	X	375
CI-COB					X	335
CI-COB	X	423			X	377
CI-COB					X	338
CI-COB					X	341
CI-COB	X	411	X	241, 302	X	361, 555
CI-COB	X	419	X	249, 300	X	371, 552
CI-COB					X	389
CI-COB	X	439	X	260	X	381
CI-COB					X	385

CI-COB	X	417	X	248	X	369
CI-COB					X	393
CI-COB					X	397
CI-COB					X	340
CI					X	481
CI-HH					X	425
CI					X	450
CI-HH					X	425
CI-HH					X	425, 426
CP			X	303	X	557
CI					X	178
CI	X	158	X	150	X	171
CD			X	139	X	160
CD	X	148	X	140	X	161
CD	X	183	X	173	X	220
CD	X	152	X	144	X	165
CD	X	149	X	141	X	162
CI-SM					X	255, 419
CI-SM					X	256, 420
CD					X	156
CD	X	146	X	137	X	158
CD	X	152	X	144	X	165
CD	X	146	X	137	X	158, 375
CD	X	146	X	137	X	158

CD	X	146	X	137	X	158
CD	X	150	X	142	X	163
CD	X	147	X	138	X	159
CD	X	154	X	146	X	167
CI					X	176, 345
CD	X	150	X	142	X	162
CD	X	107, 144			X	115, 156, 249, 413
CI	X	133	X	125	X	138
CI			X	120	X	133
CI	X	129	X	121	X	134
CI	X	130	X	122	X	135
CI	X	128, 491	X	118	X	131
CI	X	127	X	118	X	131, 550
CP			X	220	X	332
CI	X	131	X	123	X	136
CI-COB	X	102, 360	X	99, 210	X	110, 319
CI	X	131	X	123	X	136
CI			X	90	X	102
CI	X	94	X	91	X	103
CI	X	95	X	92	X	104
CI			X	88	X	100
CI	X	93	X	89	X	101
CI			X	95	X	107

CI	X	92	X	88	X	100
CI			X	89	X	100
CI			X	89	X	101
CI	X	95	X	93	X	105
CI	X	95	X	93	X	104
CI					X	404
CI-CR	X	312			X	274, 499
CI					X	486
CD	X	107, 144			X	116, 156
CI					X	200
CI	X	451			X	409
CI-CR	X	309			X	272, 496
CI					X	228, 470
CI	X	447, 492	X	267, 302	X	401, 498, 556
CI	X	492	X	303	X	557
CI	X	447, 448, 492	X	267, 303	X	401, 402, 556
CI	X	214, 311, 446, 491	X	266, 302	X	401, 498, 555
CI	X	120, 156	X	116, 148	X	129, 169
PI	X	71, 324, 331, 338, 345, 352, 465, 472, 479, 486	X	71, 190, 198, 292	X	79, 285, 293, 504, 544
CI	X	160	X	152	X	174
PI	X	72, 325, 332, 339, 346, 353, 466, 473, 480, 487	X	72, 191, 199, 293	X	80, 286, 294, 505, 545
CI					X	490

CI					X	300, 511
CI					X	489
CI					X	387
CI					X	302, 513
CI	X	306	X	281	X	462
CI					X	570
CI			X	167	X	570
CI					X	571
CI					X	571
CI					X	571
CI			X	68	X	76
CI	X	68	X	67	X	75
CI	X	68	X	67	X	75
CP	X	60, 72, 83, 85, 97, 117, 120, 124, 132, 153, 155, 185, 186, 187, 189, 191, 193, 195, 197, 198, 200, 202, 325, 326, 332, 333, 339, 340, 346, 347, 353, 357, 408, 416, 418, 422, 426, 430, 434, 438, 442, 465, 467, 473, 474, 480, 481, 487, 488	X	57, 72, 84, 85, 95, 113, 115, 124, 130, 145, 147, 175, 177, 180, 182, 184, 190, 193, 199, 201, 207, 238, 247, 249, 252, 255, 259, 263, 283, 284, 285, 292, 295, 300	X	66, 80, 92, 94, 106, 126, 128, 137, 150, 166, 168, 222, 224, 226, 228, 230, 232, 233, 235, 236, 239-242, 286, 288, 294, 296, 301, 310, 316, 357, 368, 370, 373, 376, 380, 384, 388, 392, 396, 468-470, 472, 474, 475, 477-480, 483, 504, 507, 512, 521, 527, 536, 545, 547, 552
CI			X	160	X	185, 439
CI					X	477
CI	X	343, 484	X	188	X	283, 542
CI	X	344	X	189	X	284, 543
CI	X	343, 484	X	188	X	283, 379, 542
CI	X	344, 484	X	189	X	284, 543

CI			X	192	X	287, 546
CI	X	344, 484	X	189	X	284, 543
CI	X	348, 489	X	194	X	289, 548
CI-COB	X	397			X	347
CI-CR	X	312			X	274, 499
CI	X	161, 162	X	153, 154	X	176, 177
CI			X	157	X	209
CI					X	211
CI	X	161, 391	X	153, 230	X	175, 345
CI-COB	X	393, 396, 398, 399			X	348, 349
PI			X	196, 290	X	291, 502
PI			X	197, 291	X	292, 503
PI			X	196, 290	X	291, 383, 502
PI			X	196, 290	X	292, 503
PI			X	200, 294	X	295, 506
PI			X	196, 290	X	292, 503
PI			X	202, 296	X	297, 508
CI-CR	X	309			X	272, 496
CI-CR					X	273, 497
CI-CR					X	273, 497

CI-CR	X	312			X	499
CI-CR	X	186			X	233
CI-CR					X	468
CI-CR	X	310			X	273, 497
CI-CR	X	310			X	273, 497
CI-CR	X	310			X	273, 497
CI					X	142
CI	X	136			X	143
CI	X	137			X	144
CI	X	135			X	140
CI	X	135			X	140
CI	X	135			X	141
CI	X	137			X	145
CI	X	137			X	144
CI	X	135			X	141

CI					X	250, 414
CI					X	484
CI	X	196	X	178	X	223
CI	X	457	X	165, 274	X	436
CI					X	522
CI					X	391
CP	X	491	X	302	X	555
CI	X	449			X	403
CI-HH	X	318			X	280, 493
CI					X	451
CI					X	193, 461
CI	X	163	X	155	X	178
CI					X	250, 414
CI-SM					X	252, 253, 416, 417
PI	X	65	X	64	X	72
PI	X	62	X	60	X	68
PI	X	63	X	61	X	69
PI	X	62	X	60	X	68
PI	X	62	X	60	X	68
CI-COB	X	112	X	108	X	121
CI-COB	X	116	X	112	X	125
CI-COB	X	113	X	109	X	122

CI-COB	X	109	X	104	X	118
CI-COB	X	116	X	112	X	125
CI-COB	X	109	X	104	X	118
CI-COB	X	109	X	104	X	118
CI-COB	X	110	X	105	X	118
CI-COB	X	114	X	110	X	123
CI-COB	X	110	X	106	X	119
CI-COB	X	114	X	110	X	123
CI-COB			X	107	X	120
CI-COB	X	118	X	114	X	127
PI					X	313, 524
PI					X	314, 525
PI					X	313, 395, 524
PI					X	313, 524
PI					X	315, 526
PI					X	313, 524
PI					X	317
CI	X	177			X	218
CI					X	448
CI					X	465
CP	X	159	X	151	X	172
CI					X	221
CI-HH					X	277

CP	X	503	X	313	X	572
CP	X	56, 503	X	53, 313	X	62, 572
CP	X	58	X	55	X	64
CP	X	58	X	56	X	65
CP	X	56	X	53	X	62
CP	X	58	X	55	X	64
CP	X	60	X	57	X	66
CI					X	250, 414
CI-SM					X	252, 416
CI-SM					X	255, 419, 424
CI-SM					X	252, 416
CI	X	107, 144, 307, 311, 448			X	115, 156, 249, 250, 254, 403, 413, 414, 418, 422, 498
CI					X	483
CI-HH	X	317			X	279, 492
CI					X	207
CI-SM					X	256, 420